MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2007

KAISER FOUNDATION HEALTH PLAN OF COLORADO
10350 East Dakota Avenue
Denver, CO 80231-1314

NAIC Company Code 95669
NAIC Group Code 601

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

KAISER FOUNDATION HEALTH PLAN OF COLORADO
10350 East Dakota Avenue
Denver, Colorado 80231-1314

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2007

Examination Performed by:

State Market Conduct Examiners

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW

And

Richard Kramer, CFE, AIE
Larry Cross, CFE, CIE

Independent Contract Examiners

February 13, 2009

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Kaiser Foundation Health Plan of Colorado was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-416, C.R.S., which authorize the Commissioner of Insurance to examine insurance companies and health maintenance organizations. We examined the Company's records at its office located at 2500 S. Havana, Aurora, Colorado, 80214. The market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The following market conduct examiners respectfully submit the results of the examination:

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW

Richard Kramer, CFE, AIE

Larry Cross, CFE, CIE

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COMPANY PROFILE

The following profile is based on information provided by the Company:

Kaiser Foundation Health Plan of Colorado (KFHP) is a non-profit, group practice health maintenance organization. KFHP was incorporated under Colorado state law on February 20, 1969 and began caring for enrolled members on July 1, 1969. In 1997, KFHP expanded to the Colorado Springs area. The Company had approximately 479,500 members as of December 31, 2007.

KFHP, together with its contracted physician group, the Colorado Permanente Medical Group, P.C. (CPMG), is Kaiser Permanente Colorado (KPCO). KFHP is a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP, Inc.), a California non-profit and charitable corporation, and was incorporated under Colorado state law on February 20, 1969.

KFHP operates in the greater Denver/Boulder metropolitan area and in Colorado Springs. Its primary operating area includes specific areas (defined by zip code) of the following counties: Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld (Denver/Boulder metropolitan area), El Paso, Fremont, Lincoln, Park, and Teller (Colorado Springs area), Mesa and Pueblo. The Denver/Boulder market comprises more than 90 percent of the region's membership (commercial and Medicare) and is structured as a group practice HMO. The Colorado Springs service area comprises the remainder of the region's membership, is structured as a true network, and offers a commercial product only.

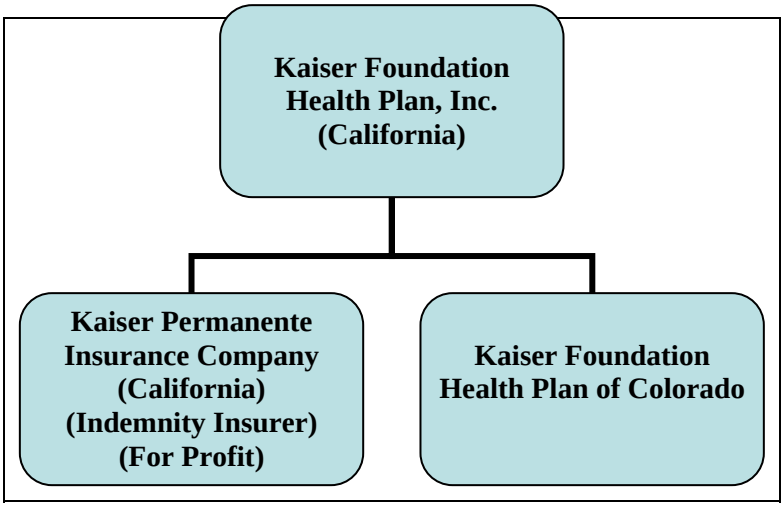
Kaiser Foundation Health Plan of Colorado was federally qualified as a Health Maintenance Organization pursuant to the Public Health Service Act on October 27, 1977.

KFHP received its current Certificate of Authority in Colorado on July 5, 1990.

A corporate structure chart as of December 31, 2007 is shown below.

STRUCTURE AS OF DECEMBER 31, 2007

The following organizational chart depicts the Company's relationship within the company structure as of December 31, 2007.



Service Area

KFHP operates in the greater Denver/Boulder metropolitan area and in Colorado Springs in specific areas (defined by zip code) of the following counties: Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld (Denver/Boulder metropolitan area), El Paso, Fremont, Lincoln, Park, and Teller (Colorado Springs area), Mesa and Pueblo.

Enrollment as of December 31, 2007:	479,535
Total Written Premium:	$2,020,801,000
Small Group Written Premium:	$255,432,932

Market Share	(as a percentage of Colorado Total Accident and Health):	14.49%
	(as a percentage of Colorado Total Small Group):	20.04%

Health Care Delivery:

Kaiser Foundation Health Plan of Colorado, servicing the Denver/Boulder areas, owns and operates its own medical facilities with contracted physicians. Kaiser Foundation Health Plan of Colorado servicing the Colorado Springs area contracts with independent physician associations, physician group practices, and independent physicians. In Denver/Boulder and in Colorado Springs Kaiser contracts with hospitals.

PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance (Division), who were assisted by independent contract examiners, reviewed certain business practices of Kaiser Foundation Health Plan of Colorado. The limited market conduct examination was performed in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-416, C.R.S., which empower the Commissioner to examine any entity engaged in the business of insurance The information in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related primarily to HMOs. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or submitted by the Company. The limited market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The examination included review of the following:

Company Operations and Management
Complaints
Producers
Contract Forms
Rating
Underwriting: Applications & Renewals, Cancellations, Nonrenewals, Declinations and Rescissions
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not appear to contain any improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms permit the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance laws as they pertained to HMOs. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. The examination was conducted concurrently with an examination of Kaiser Permanente Insurance Company. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions - definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans – rules – benefit design advisory committee – repeal.
Section 10-16-105.2, C.R.S.	Small employer health insurance availability program.
Section 10-16-105.5, C.R.S.	Individual health plans – federally eligible individual – limited guarantee issue
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – loss ration guarantees – disclosures on treatment of intractable pain
Section 10-16-107.2 C.R.S.	Filing of health policies
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-108.5, C.R.S.	Fair marketing standards.
Section 10-16-109. C.R.S.	Rules and regulations.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modifications of health benefit plans.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-401, C.R.S.	Establishment of health maintenance organizations.
Section 10-16-403, C.R.S.	Prohibited practices.
Section 10-16-407, C.R.S.	Information to enrollees.
Section 10-16-413, C.R.S.	Prohibited practices
Section 10-16-416, C.R.S.	Examination
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.

Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-1	Replacement of Accident and Health Insurance.
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy" for Use in Accident and Health Insurance Contracts and Certificates
Insurance Regulation 4-2-8	Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation Of Health Plan Claims Involving Utilization Review
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued to Self-Employed Business Groups of One
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers
Insurance Regulation 4-6-2	Group Coordination of Benefits.
Insurance Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form and Eligibility Requirements.
Insurance Regulation 4-6-5	Concerning Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Health Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Conversion Coverage
Insurance Regulation 4-7-2	Concerning The Laws Regulating Health Maintenance Organizations Benefit Contracts and Services In Colorado

Company Operations and Management

The examiners reviewed Company management and administrative controls, including provider contracts, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was most recently the subject of a previous market conduct examination dated December 31, 2001, which covered the period of January 1, 2001 through December 31, 2001. The Company was also the subject of a financial examination conducted by the Division's financial examiners that was completed in April 2007, and covered the period of January 1, 2001 through December 31, 2005.

Contract Forms

The examiners reviewed the following forms:

- The Company's Basic and Standard HMO Plans, co-payment schedules and schedules of benefits;
- The Company's most commonly sold HMO group certificates.
- The Company's HMO conversion certificates, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee HMO applications/enrollment forms and supporting documents.

These plans were issued and/or certified with the Division between January 1, 2007 and December 31, 2007.

New Business Applications and Renewals

The examiners reviewed:

- A sample of fifty (50) small group new business application files;
- A sample of 100 individual application files
- A sample of 100 small group renewal files;
- A sample of 100 individual renewal files and
- The Company's rating of both new business application files and renewal files for small group and individual files were reviewed from the above four samples of files.

Cancellations/Terminations/Declinations

The examiners reviewed a random sample of fifty (50) involuntary cancellations and voluntary termination files from the total population of 5,047 individual cancellations and a random sample of fifty-six (56) involuntary cancellations and voluntary termination files from the total population of 102 small group files. The examiners reviewed a random sample of fifty (50) cancellation files from the total population of 4,500 individual cancellations and the entire population of thirty-nine (39) small group declination files.

Claims

In order to determine the Company's compliance with Colorado's prompt payment of claims law, as well as the proper and accurate payment of claims, the examiners reviewed the following random samples:

- Fifty (50) electronic claims paid or denied beyond thirty (30) days;
- Fifty (50) non-electronic claims paid or denied beyond forty-five(45) days;
- Fifty (50) claims paid or denied beyond ninety (90) days; and
- One hundred (100) paid claims were reviewed for accuracy of payment.
- One hundred (100) denied claims were reviewed for accuracy of denial.
- Fifty (50) claims denied as "not covered benefits".

Utilization Review

The examiners reviewed copies of the Company's Appeals Guide along with its utilization review policies and procedures, and the following random samples and/or entire populations of utilization review files in order to determine compliance with Colorado insurance law:

- One hundred (100) utilization review approval files;
- Fifty (50) utilization review denial files;
- Fifty (50) first level utilization review appeal files;
- The entire population of thirty-one (31) voluntary second level utilization review appeal files, and
- The entire population of eight (8) external review appeal files.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirty-one (31) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings.

Company Operations and Management: The examiners identified two (2) areas of concern in the review of Company Operations and Management.

Issue A1: Failure, in some instances, to maintain and to provide, upon request, records and documents required for market conduct purposes.

Issue A2. Failure of the Company's provider contracts, in some cases, to contain all required elements in the "Hold Harmless" provisions.

Contract Forms: The examiners identified fifteen (15) areas of concern in their review of the Company's contract forms.

Issue E1: Failure of the Company's forms, in some instances, to provide coverage for a newborn or adopted dependent to the extent required by Colorado insurance law.

Issue E2: Failure to correctly title the Basic and Standard health benefit plans and to provide a separate form for each plan and type of plan as required.

Issue E3: Failure of the Company's group forms to reflect correct information regarding termination and continuation of coverage.

Issue E4: Failure, in some instances, to include correct copays and coinsurance requirements in the Basic and Standard Membership Agreement and Evidence of Coverage forms.

Issue E5: Failure, in some instances, to limit coverage in the Basic and Standard health benefit plans to the required benefits.

Issue E6: Failure, in some instances, to include correct eligibility requirements in the membership agreements with regard to living or working within the service area.

Issue E7: Failure to include all qualifying events in the special enrollment provisions of the Company's Evidence of Coverage forms.

Issue E8: Failure, in some instances, to include information in the Company's forms regarding the required offer of extending coverage for unmarried dependent children under age twenty-five.

Issue E9: Failure, in some cases, to include in the Company's forms all required elements of the entire contract provision.

Issue E10: Failure, in some cases, to provide mandated coverage for maternity care.

Issue E11: Failure, in some instances, to provide accurate information regarding coverage for emergency services.

Issue E12: Failure to include the required form and content in the Basic and Standard health benefit plan forms.

Issue E13: Failure to include information regarding payment of claims that complies with Colorado insurance law.

Issue E14: Failure, in some instances, to provide accurate information regarding tracking of member co-payments and out-of-pocket maximums. *(This was prior issue E3 in the market conduct examination report dated December 31, 1996.)*

Issue E15 Failure, in some cases, to file and certify compliance of forms prior to their use.

New Business Applications and Renewals: The examiners identified one (1) area of concern in their review of the new business applications and renewal handling practices of the Company.

Issue G1: Failure to ensure all applicants for individual coverage complete the "Determination of Self-Employed Business Group of One Form." *(This was a partial repeat of prior issue G1 in the market conduct examination report dated December 31, 2001.*

Cancellations/Declinations/Terminations: The examiners identified eight (8) areas of concern in their review of the cancellation/declination/termination practices of the Company.

Issue H1: Failure of the Company's CoverColorado Notice Form to contain all required disclosure elements.

Issue H2: Failure, in some instances, to provide a written notice of declination and/or not providing sufficient written detail as to the reason for denial of coverage.

Issue H3: Failure, in some instances, to provide written notice of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan.

Issue H4: Failure of the Company's Certificates of Creditable Coverage to reflect the full definition of a "significant break in coverage".

Issue H5: Failure, in some instances, to provide Certificates of Creditable Coverage.

Issue H6: Failure, in some instances, to provide Certificates of Creditable Coverage that reflect the correct dates of coverage under individual health benefit plans.

Issue H7: Failure, in some instances, to provide written notice of the availability of Basic and Standard Health Benefit plans to business groups of one that were denied coverage for another group health plan due to risk characteristics. *(This was prior issue H1 in the market conduct examination report dated December 31, 2001.)*

Issue H8: Failure, in some instances, to provide written notification of the denial of coverage, including the specific reason(s) for denial to business group of one applicants who were denied coverage under a small group plan.

Claims: The examiners identified four (4) areas of concern in their review of the claims handling practices of the Company.

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to pend unclean claims and to allow the required time for submission of additional information before denying.

Issue J3: Failure, in some instances, to correctly adjudicate claims resulting in erroneous denials and requiring subsequent, delayed correct adjudication and payment of claims.

Issue J4: Failure, in some instances, to provide required information regarding appeal rights to members whose claims were denied.

Utilization Review: The examiners identified one (1) area of concern in their review of the Company's utilization review procedures.

Issue K1: Failure to provide the qualifying credentials of all panel members in the appeal decision letter as required pursuant to Colorado Insurance Regulation 4-2-17.

A copy of the Company's response, if applicable, can be obtained by contacting the Company. Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

KAISER FOUNDATION HEALTH PLAN OF COLORADO

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure, in some instances, to maintain and to provide, upon request, records and documents required for market conduct purposes.

Colorado Insurance Regulation 1-1-7, Market Conduct Record Retention, promulgated under authority of Section 10-1-109(1), C.R.S., states in part:

Section 3. Definitions

A. *"Application records" mean* any written or electronic application form, any enrollment form, any document used to add coverage under an existing policy, any questionnaire, telephone interview form, paramedical interview form, *or any other document used* to question *or underwrite an applicant for a policy issued by an insurer or for any declination of coverage by an insurer.*

F. *"Declination" or "declination records" mean* all written or electronic records concerning a policy for which an application for insurance coverage has been completed and submitted to the insurer or its producer but the insurer has made a determination not to issue a policy or not to add additional coverage when requested. Declined underwriting records shall include an application, any documentation substantiating the decision to decline issuance of a policy, any binder issued without the insurer issuing a policy, any documentation substantiating the decision not to add additional coverage when requested and, if required by law, *any declination notification*. Notes regarding requests for quotations that do not result in completed application of for coverage need not be maintained for purposes of this regulation.

Section 4. Records Required For Market Conduct Purposes

A. *Every entity subject to the Market Conduct process shall maintain its books, records, documents and other business records in a manner so that the following practices of the entity subject to the Market Conduct process may be readily ascertained during market conduct examinations, including but not limited to,* company operations and management, policyholder services, claims practices, rating, *underwriting,* marketing, complaint/grievance handling, producer licensing records, and additionally for health insurers/carriers or related entities: network adequacy, utilization review, quality assessment and improvement, and provider credentialing. Records for this regulation regarding market conduct purposes shall be maintained for the current calendar year plus two calendar years.

Section 5. Policy Records

A. The following records shall be maintained: A policy record shall be maintained for each policy issued. *Policy record shall be maintained so as to show clearly the policy period,* basis for rating and any imposition of additional exclusions from or exceptions to coverage. *If a policy is terminated, either by the insurer or the policyholder, documentation supporting the termination and account records indicating a return of*

premiums, if any, shall also be maintained. Policy records need not be segregated form the policy records of another state so long as records are readily available to market conduct examiners as required under this regulation.

B. *Policy records shall include at least the following*:

(1) The actual, completed application for each contract, where applicable;

(a) *The application shall bear the signature, either written or digitally authenticated, where required, of the applicant* whenever the insurer intends to retain any right to contest any warranty, representation or condition contained in the application; or

(2) Any declaration pages (the initial page and any subsequent pages), the insurance contract, any certificates evidencing coverage under a group contract, any endorsements or riders associated with a policy, any termination notices, *and any written or electronic correspondence to or from the insured pertaining to the coverage. A separate copy of the record need not be maintained in the individual policy to which the record pertains, provided* it is clear from the insurer's other records or systems that the record applies to a particular policy and *that any data contained in the record relating to the a policy, as well as the actual policy, can be retrieved or recreated;*

Section 9. Format of Records

A. *Any record required to be maintained by an insurer may be in the form of paper, photograph, magnetic, mechanical or electronic medium; or any process that accurately forms a durable reproduction of the record, so long as the record is capable of duplication to a hard copy that is as legible as the original document.* Documents that are produced and sent to an insured by use of a template and an electronic mail list shall be considered to be sufficiently reproduced if the insurer can provide proof of mailing of the documents and a copy of the template. *Documents that require the signature of the insured or insurer's producer shall be maintained in any format listed above, provided evidence of the signatures is preserved in that format.*

B. The maintenance of records in a computer-based format shall be archival in nature, so as to preclude the alteration of the record after the initial transfer to a computer formation. *Upon request of an examiner, all records shall be capable of duplication to a hard copy that is as legible as the original document.* The records shall be maintained according to written procedures developed and adhered to by the insurer. The written procedures shall be made available to the commissioner's market conduct examiners in accordance with Section 12.

Section 10. Location of Records

A. *All records required to be maintained under this regulation shall be kept in a location or locations that will allow the records to be produced for examination within the time period required under Section 11.*

Section 12. *Records Usually Required for Examination*

F. Underwriting and rating practices: annual rate filing, company rating plan and rates, disclosure, producer payments, credits, deviations, schedule rating, IRPM plans, expense/loss cost multipliers, statistical coding/reporting, premium audits, loss reporting, policy forms and filings, underwriting policies, procedures, and manuals, *declinations/rejections*, cancellations/renewals, rescissions, *policyholder records* (applications, policy riders, *correspondence,* policy forms), guaranteed issue, pre-existing conditions and privacy of protected personal information. [Emphases added.]

Colorado Insurance Regulation 4-7-2, Concerning The Laws Regarding Health Maintenance Organizations Benefit Contracts And Services In Colorado, promulgated under authority of Section 10-1-109(1), C.R.S., states in part:

Section 5. *Requirements for Benefits Contracts and Evidence of Coverage*

C. Terms of Coverage

The contract and/or evidence of coverage shall contain the time and date or occurrence upon which coverage takes effect and include any applicable waiting periods. . [Emphases added.]

INDIVIDUAL APPLICATION FILES

Population	Sample Size	Number of Exceptions	Percentage to Sample
7165	100	8	8%

It appears the Company is not in compliance with Colorado insurance law in that it has been unable to provide copies of welcome/approval letters for six (6) individual applicants or family members of the applicant in the sample of 100 new individual applications reviewed. The approval letter appears to be the only correspondence or other notification the Company provides to a new enrollee of the specific effective date of coverage, which must be provided. The Company was also unable to provide copies of two (2) denial letters for individuals whose coverage the Company declined. The Company stated in an email dated 12/22/2008 that these eight (8) documents are irretrievable.

In addition, the Company stated it does retain but cannot reproduce with signatures certain documents requiring signature at the time of application. This was addressed under New Business Applications and Renewals in Issue G2 but is included here only for the Company's information. The inability to produce those signed documents is a record retention issue as well as an Applications issue. Colorado insurance law requires the Company to retain these documents, accurately reproduce them and make them available for review during a market conduct examination.

Finally, the Company provided no copies of account records to allow the examiners to determine whether the company’s indication of return premium owed or not, was correct and, if owed, that the correct amount was returned for the individual and small group termination samples of 100 and fifty (50) files each, respectively.

INDIVIDUAL CANCELLATION FILES

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,047	100	100	100%

GROUP CANCELLATION FILES

Population	Sample Size	Number of Exceptions	Percentage to Sample
102	50	50	100%

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulations 1-1-7 and 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its record maintenance procedures to ensure that all records required for market conduct purposes are maintained and can be provided within the time periods required by Colorado insurance law.

Issue A2. Failure of the Company's provider contracts, in some cases, to contain all required elements in the "Hold Harmless" provisions.

Colorado Insurance Regulation 4-7-1, Health Maintenance Organizations, promulgated pursuant to §§10-1-109, 10-16-401(4)(o); and 10-16-403(2)(b), C.R.S., states in part:

Section 12. Provider Agreements

B. In order to qualify as a covered expenditure, a provider, intermediary, IPA or other provider group contract or provider subcontract *must have a "hold harmless" provision which substantially complies with the following*:

1. Provider agrees that in no event, including but not limited to nonpayment by the HMO, insolvency of the HMO or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or persons (other than the HMO) acting on his/their behalf for services provided pursuant to this agreement. This provision does not prohibit the provider from collecting supplemental charges or copayments or fees for uncovered services delivered on a 'fee-for-service' basis to HMO subscribers/enrollees.

2. Provider agrees that this provision shall survive the termination of this agreement, for authorized services rendered prior to the termination of this agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollees. This provision is not intended to apply to services provided after this agreement has been terminations

3. Provider agrees that this provision supersedes any oral or written contrary agreement now or existing hereafter entered into between the provider and the subscriber, enrollee or persons acting on their behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of this agreement. [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that its Provider contract forms do not meet all of the requirements set forth in Colorado Insurance Regulation 4-7-1. There are no statements included in the contracts regarding the continuation of the hold harmless provisions even after termination of the contracts, nor that these provisions supersede any oral or written contrary agreement.

The Company's Provider contracts state the following:

3.3 **Member Hold Harmless.** Except as expressly provided in Section 3.4 (Billing Members), Provider (and any subcontractors) shall look solely to the responsible Payor for compensation for Covered Services rendered to Members, and Provider agrees that in no event (Including non-payment by Payor, insolvency of Payor or breach of this Agreement) shall Provider (or Subcontractor) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, person acting on the Member's behalf, Official, State or any Medicaid plans, for Covered Services provided under this Agreement. Without limiting the foregoing,

Provider shall not seek payment from Members for amounts denied by Payor because (i) billed charges were not customary or reasonable, (ii) the services were not medically necessary, (iii) the Services were not Authorized, or (iv) Provider failed to submit claims within the appropriate time frame or in accordance with the Provider Manual.

Form	Form Number
Colorado CPMG Model Physician Contract	351313v4
Colorado Model Hospital Contract	348010v3
KFHP Colorado Model Ancillary Contract	351787v3

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-7-1. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its provider contracts to comply with Colorado insurance law.

CONTRACT FORMS

Issue E1: Failure of the Company's forms, in some instances, to provide coverage for a newborn or adopted dependent to the extent required by Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn children

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period. [Emphasis added.]

(e) The requirements of this section shall apply to all individual sickness and accident policies issued on and or after July 1, 1975, and to all blanket and group sickness and accident policies issued, renewed, or reinstated on and after July 1, 1975, and to all subscriber or enrollee coverage contracts delivered or issued for delivery in this state on and after July 1, 1975.

(6.5) Adopted child - dependent coverage**.**

(a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, *the entity* shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber *under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber*, regardless of whether adoption of the child is final. [Emphasis added.]

It appears the Company is not in compliance with Colorado insurance law in that its membership agreement and evidence of coverage forms require enrollment of newborn and newly adopted children within thirty-one (31) days in order for coverage to continue beyond thirty-one (31) days even if the subscriber already has family coverage and no additional premium would be required to add the additional child.

The Company's Basic and Standard forms for individuals include the following provisions:

B. Adding Dependents

1. Adding Newborn and Newly Adopted Children

You may add a newborn child or a newly adopted child as your Dependent. To do this you must contact Member Services and enroll the child within 31 days after the child becomes your Dependent. The 31-day period for newborns begins at birth. The 31-day period for adoptees begins when the child is placed in your custody.

No health screening is required for children during this 31-day period. *After the 31-day period, children must meet any current requirements for individual membership, including passing a health screening*. [Emphasis added.]

C. When coverage Starts

1. Newborn Children
An eligible newborn child is covered under the terms of this Membership Agreement from birth. *Coverage ends after 31 days unless you enroll the child and pay the applicable Dues.* In order to be covered, all Services must be provided or arranged by a Plan Physician except for Emergency Services." (Emphasis added.)

2. Newly Adopted Children
An eligible newly adopted child is covered from the date he or she is placed in your custody *only if you enroll the child by submitting a completed Change Form to Health Plan within 31 days after placement and* pay any applicable Dues. (Emphasis added.)

The Company's small group evidence of coverage form includes the following provisions:

Adding Dependents

Adding Newborn and Newly Adopted Children

You may add a newborn child or a newly adopted child as your Dependent. To do this you must contact Member Services and enroll the child within 31 days after the child becomes your Dependent. The 31-day period for newborns begins at birth. The 31-day period for adoptees begins when the child is placed in your custody.

No health screening is required for children during this 31-day period. *After the 31-day period, children must meet any current requirements for individual membership, including passing a health screening*. [Emphases added.]

When Coverage Starts

Newborn Children

An eligible newborn child is covered under the terms of this Membership Agreement from birth. *Coverage ends after 31 days unless you enroll the child and pay the applicable Dues.* In order to be covered, all Services must be provided or arranged by a Plan Physician except for emergency services." [Emphasis added.]

Newly Adopted Children

An eligible newly adopted child is covered from the date he or she is placed in your custody *only if you enroll the child by submitting a completed Change Form to Health Plan within 31 days after placement and* pay any applicable Dues. [Emphasis added.]

Colorado law does not allow the Company to require evidence of insurability for a newborn or newly adopted child if the subscriber already has family coverage even though the child may not have been enrolled within thirty-one (31) days of the birth or placement for adoption. This includes requiring the newborn child or newly adopted child to pass a health screening.

Colorado law allows the Company to terminate coverage for a newborn or newly adopted child after the first thirty-one (31) days if the subscriber has other than family coverage (i.e. subscriber + spouse only) if said enrollment would result in an additional premium and such premium is not paid within thirty-one (31) days after the birth or placement of the child for adoption.

Form:	Date:
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06
SGEOC-DENCOS	01/07

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why its forms should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to ensure that newborn and newly adopted children are covered as required by Colorado insurance law.

Issue E2: Failure to correctly title the Basic and Standard health benefit plans and to provide a separate form for each plan and type of plan as required.

Section 10-16-105, C.R.S., Small Group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal, states in part:

(7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. The commissioner shall survey small group carriers to determine the range of health benefit plans available annually. The commissioner shall implement a basic plan that approximates the lowest level of coverage offered in small group health benefit plans. A basic health benefit plan may be based on the latest medical evidence. The commissioner shall implement a standard plan that approximates the average level of coverage offered in small group health benefit plans. In determining levels of coverage, the commissioner shall consider factors such as coinsurance, copayments, deductibles, out-of-pocket maximums, and covered benefits. The commissioner shall amend the rules to implement the basic and standard health benefit plans no more frequently than once every two years. The rules shall be in conformity with article 4 of title 24, C.R.S., and shall incorporate the following standard health benefit plan design described in paragraph (a) of this subsection (7.2) and the various options for the basic health benefit plan design described in paragraph (b) of this subsection (7.2):

(a) The standard health benefit plan shall reflect the benefit design of common plan offerings in the small group market and may reflect a plan design that has a deductible amount of two thousand five hundred dollars for which the covered person is responsible after the first one thousand dollars of coverage has been provided by an employer in a manner similar to a personal care account;

(b)(I) A basic health benefit plan may reflect a basic health benefit plan that does not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 (4), (5), (8), (9), (10), and (12).

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated under authority of Sections 10-1-109, 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 4. Rules

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S.*

However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a conversion plan.

2. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.*

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name][Type of plan (i.e. Indemnity, Preferred Provider or HMO)(Basic Limited Mandate Health Benefit Plan, Basic HSA Health Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan)] for Colorado".

2. Each small employer carrier shall title and market the standard health benefit plan as follows: "[Carrier name] [Type of plan (i.e. Indemnity, Preferred Provider or HMO] Standard Health Benefit Plan for Colorado". [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that its Basic and Standard health benefit plans' membership agreements and evidence of coverage forms are titled incorrectly and combine both the Basic and Standard plans into one form. The Basic plan title in each form includes the description "without specified mandates", which is not one of the three plan design options required under Regulation 4-6-5 during 2007. In addition, the Company must include the type of plan offered (i.e. HMO), in the title, and must have a separate Basic and a Standard form for each individual and group type of plan. The Basic and Standard health benefit plans may not be combined into the same form.

Form:	Date:
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06
SGEOC-DENCOS	01/07

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-105, C.R.S., and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its Basic and Standard health benefit plan forms to reflect the correct titles and benefits as required by Colorado insurance law.

Issue E3: Failure of the Company's group forms to reflect correct information regarding termination and continuation of coverage.

Section 10-16-102, C.R.S., Definitions, states, in part:

> (21)(a) "Health benefit plan" means any hospital or medical expense policy or certificate, hospital or medical service corporation contract, or health maintenance organization subscriber contract or any other similar health contract subject to the jurisdiction of the commissioner available for use, offered, or sold in Colorado.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states, in part:

> (2) Group contracts of non-profit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.
>
> (a) Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by a nonprofit hospital, medical-surgical, and health service corporation or a health maintenance organization operating with a certificate of authority pursuant to part 3 or 4 of this article shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. Such provision shall conform to the requirements, where applicable, of paragraphs (b), (c), and (d) of this subsection (2).
>
> (b)(III) The employer shall not be required to *offer* continuation of coverage of any person if such person *is covered* by Medicare, Title XVIII of the federal "Social Security Act," or Medicaid, Title XIX of the federal "Social Security Act."
>
> (c)(I) Upon the termination of employment of an eligible employee, the death of any such employee, or the change in marital status of any such employee, *the employee or dependent has the right to continue the coverage for a period of eighteen months* after loss of coverage or until such employee or dependent becomes *eligible for other group coverage*. However, should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the eighteen months or until the new plan covers the condition, whichever occurs first. [Emphases added.]

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states, in part:

> (1) A carrier providing coverage under a health benefit plan *shall not discontinue coverage or refuse to renew such plan except for the following reasons:*

(a) *Nonpayment of the required premium;*

(b) *Fraud or intentional misrepresentation of material fact on the part of the* plan sponsor with respect to group health benefit plan coverage and the *individual with respect to individual coverage;* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its group evidence of coverage forms provide that the coverage of individual Members currently enrolled and otherwise eligible for coverage, will be terminated if the Member does not enroll in Medicare when he or she becomes eligible. In addition, these forms provide that continuation coverage will terminate when the Member becomes entitled to Medicare benefits.

Colorado insurance law does not allow termination of an HMO member solely because the Member fails to enroll in Medicare when he or she becomes eligible. In addition, Colorado insurance law states that an offer of continuation of coverage need not be extended if the Member is *already* covered by Medicare or Medicaid when he or she becomes eligible for continuation of coverage. However, neither Medicare nor Medicaid is "group" coverage, and the carrier is not allowed to terminate coverage solely because a Member *fails to enroll in Medicare when he or she becomes eligible* for and/or *covered by* Medicare or Medicaid while enrolled in continuation coverage.

The Company's membership agreements and evidence of coverage forms state, in part:

E. Termination for Noncompliance with Medicare Membership Requirements
For Members entitled to Medicare, Medicare is primary coverage except when federal law (TEFRA) requires that Group's health care plan be primary and Medicare coverage be secondary. Members eligible for Medicare as their secondary coverage are subject to the same Dues and receive the same benefits as Members who are not eligible for Medicare, except that Members who enroll in our Kaiser Permanente Senior Advantage as Secondary Payor plan will have no Copayments or Coinsurance for most covered Services.

*(If you do not comply with all of the following requirements for any reason, even if you are unable to enroll in Kaiser Permanente Senior Advantage plan because you do not meet the plan's eligibility requirements, or the plan is not available through your Group or Service Area, we will terminate your membership upon 30 day's written notice to the Subscriber.)**

For Members eligible for Medicare as primary coverage, Dues are based on the assumption that Health Plan or its designee will receive Medicare-covered Services provided to Members eligible for benefits under Medicare Part A or B (or both). *If you are or become eligible for Medicare as primary coverage, you must comply with the following requirements:*

1. *Enroll in all parts of Medicare for which you are eligible and continue that enrollment while a Member; and*
2. *Denver/Boulder Members: enroll through your Group in a Kaiser Permanente Senior Advantage plan,*
   Colorado Springs Members: assign your Medicare benefits to Health Plan; and

3. Complete and submit all documents necessary for Health Plan, or any provider from whom you receive Services covered by Health Plan, to obtain Medicare payments for Medicare-covered Services provided to you.

F. Continuation of Group Coverage Under Federal Law, State Law or USERRA Termination of State Continuation Coverage. *Continuation of coverage under this provision continues upon payment of the applicable Dues to your Group and terminates on the earlier of:*

a. 18-months after your coverage would have otherwise terminated because of termination of employment; or
b. *The date you become entitled to Medicare, or*
c. The date you become covered under another group medical plan; or
d. The date Kaiser Permanente terminates its contract with the Group. [Emphases added]

Form:	Date:
SGEOC-DENCOS	01/07
CLEOC-DENCOS	01/07
LGEOC-DENCOS	01/07

* This paragraph appears only in LGEOC-DENCOS (01/07)

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102, 10-16-108, and 10-16-201.5 C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to provide accurate information regarding termination and continuation of coverage to comply with Colorado insurance law.

Issue E4: Failure, in some instances, to include correct copays and coinsurance requirements in the Basic and Standard Membership Agreement and Evidence of Coverage forms.

Section 10-16-105, C.R.S., Small Group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal, states in part:

> (7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. The commissioner shall survey small group carriers to determine the range of health benefit plans available annually. *The commissioner shall implement a basic plan that approximates the lowest level of coverage offered in small group health benefit plans.* A basic health benefit plan may be based on the latest medical evidence. *The commissioner shall implement a standard plan that approximates the average level of coverage offered in small group health benefit plans.* In determining levels of coverage, the commissioner shall consider factors such as coinsurance, copayments, deductibles, out-of-pocket maximums, and covered benefits. The commissioner shall amend the rules to implement the basic and standard health benefit plans no more frequently than once every two years. The rules shall be in conformity with article 4 of title 24, C.R.S., and shall incorporate the following standard health benefit plan design described in paragraph (a) of this subsection (7.2) and the various options for the basic health benefit plan design described in paragraph (b) of this subsection (7.2): [Emphases added.]

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated under authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2. Background and Scope

> The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans.*

Section 4. Rules

> A. Plans
>
> 1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S.* However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to

every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.*

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. *The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2) (b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or Basic HSA Limited Mandate Health Benefit Plan".*

2. *The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".* [Emphases added.)

It appears the Company is not in compliance with Colorado insurance law in that, in some instances, the Company's Basic and Standard Membership Agreement and Evidence of Coverage forms do not include the correct coinsurance or copayment amounts for some benefits and include additional costs for the member that are not permitted in the basic and standard health benefit plans' requirements.

Some specific issues identified by the examiners are:

- Including a deductible of 50% of charges, which is different than is required for a prescription brand name drug when a generic equivalent drug is the preferred product,

- Including a copay of 50% of charges, which is different than is required for any other covered medical treatment for infertility services, including X-rays, laboratory and special procedures.

The Company's forms state, in part:

Drugs, Supplies and Supplements

"A. Drugs for which a prescription is required by law. Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Physician. *If a Member requests a brand-name drug when a generic equivalent drug is the preferred product, the Member must pay $30 (Standard Plan)/$50 (Basic Plan), plus any difference between the preferred generic equivalent prescribed by the Plan Physician and the requested brand-name.* If the brand-name drug is prescribed due to Medical Necessity, the Member pays only the brand-name Copayment. [Emphasis added.]

Infertility Services
Standard/Basic: 50% of Charges

X-ray, Laboratory and Special Procedures

- X-ray and laboratory Services and procedure for the treatment of infertility and conception by artificial means.
  Standard and Basic: 50% of Charges

Form:	Date:
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06
SGEOC-DENCOS	01/07

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-105, C.R.S. and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to reflect correct copay and coinsurance requirements for the Basic and Standard plans as required by Colorado insurance law.

Issue E5: Failure, in some instances, to limit coverage in the Basic and Standard health benefit plans to the required benefits.

Section 10-16-105, C.R.S., Small Group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal, states in part:

(5)(g)(I) That the small employer purchasing any health benefit plan *other than a basic plan* pursuant to paragraph (b) of subsection (7.2) of this section, must pay for all of the mandated benefits pursuant to section 10-16-104 and that these mandates include mandatory, nonwaivable coverages for newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, and prosthetic devices.

(7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. The commissioner shall survey small group carriers to determine the range of health benefit plans available annually. *The commissioner shall implement a basic plan that approximates the lowest level of coverage offered in small group health benefit plans.* A basic health benefit plan may be based on the latest medical evidence. *The commissioner shall implement a standard plan that approximates the average level of coverage offered in small group health benefit plans.* In determining levels of coverage, the commissioner shall consider factors such as coinsurance, copayments, deductibles, out-of-pocket maximums, and covered benefits. The commissioner shall amend the rules to implement the basic and standard health benefit plans no more frequently than once every two years. The rules shall be in conformity with article 4 of title 24, C.R.S., and shall incorporate the following standard health benefit plan design described in paragraph (a) of this subsection (7.2) and the various options for the basic health benefit plan design described in paragraph (b) of this subsection (7.2): [Emphases added.]

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated under authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2. Background and Scope

The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans.*

Section 4. Rules

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S.* However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.* [Emphases added.]

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. *The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or Basic HSA Limited Mandate Health Benefit Plan".*

2. *The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".*

5. *All basic and standard health benefit plans shall also comply with the following requirements:*

B. Benefit Modifications: The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" *may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only.*

It appears the Company is not in compliance with Colorado insurance law in that the Company's Basic and Standard Membership Agreement and Evidence of Coverage forms include expanded coverage for specifically named conditions and treatments and by not

correctly excluding other conditions and treatments from coverage without the addition of a rider or endorsement.

Some specific issues identified by the examiners are:

- congenital hemangioma (known as port wine stains)
- pulmonary rehabilitation
- excluding only bariatric surgery and cosmetic surgery related to bariatric surgery instead of excluding all charges related to surgical treatment of obesity,
- failing to exclude educational training problems, learning disorders and war.
- excluding some treatments, marital and social counseling, sexual dysfunction and treatments not medically necessary by including them as exceptions under benefits rather than under exclusions under the required heading.

The Company's forms state in part:

O. **Physical, Occupational and Speech Therapy Services**

1. Coverage
   c. Pulmonary Rehabilitation
   Standard/Basic: $5 per visit

   Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities. Clinical criteria is used to determine appropriate candidacy for the program, which consists of an initial evaluation, up to six education sessions, up to twelve exercise sessions and a final evaluation to be completed within a two or three-month period.

   Limitation: Participation in a pulmonary rehabilitation program is limited to once per lifetime.

P. Reconstructive Surgery
Standard/Basic: Copayment for Hospital Inpatient Care applies

1. Coverage
   We cover reconstructive surgery when a Plan Physician determines it: (a) will correct significant disfigurement caused by medically necessary surgery or (b) will correct congenital defect, disease or anomaly in order to produce significant improvement in physical function, or (c) *will treat congenital hemangioma (known as port wine stains) on the face or neck of members 18 years and younger*. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment of physical complications including lymphedemas. [Emphasis added.]

Physical, Occupational and Speech Therapy Services

Pulmonary Rehabilitation

Standard/Basic: $5 per visit

Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities. Clinical criteria is

used to determine appropriate candidacy for the program, which consists of an initial evaluation, up to six education sessions, up to twelve exercise sessions and a final evaluation to be completed within a two or three-month period.

Limitation: Participation in a pulmonary rehabilitation program is limited to once per lifetime.

Reconstructive Surgery

Standard/Basic: Copayment for Hospital Inpatient Care applies

We cover reconstructive surgery when a Plan Physician determines it: (a) will correct significant disfigurement caused by medically necessary surgery or (b) will correct congenital defect, disease or anomaly in order to produce significant improvement in physical function, or (c*) will treat congenital hemangioma (known as port wine stains) on the face or neck of members 18 years and younger*. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment of physical complications including lymphedemas. [Emphasis added]

Form:	Date:
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06
SGEOC-DENCOS	01/07

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-105, C.R.S. and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its Basic and Standard health plan forms to reflect only required benefits to comply with Colorado insurance law.

Issue E6: Failure, in some instances, to include correct eligibility requirements in the membership agreements with regard to living or working within the service area.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states, in part:

> (2) Group contracts of non-profit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.
>
> (d) *A group contract or group service contract that provides for continued coverage after an employee is terminated, as required by paragraph (a) of this subsection (2), shall also include a provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage, to obtain from the insurer underwriting the group contract or group service contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual service contract or contract providing hospital, medical-surgical, or other health services which shall conform to the same type of descriptions, limitations, and requirements as those specified for converted policies pursuant to subparagraph (I) of paragraph (c) of subsection (1) of this section.*
>
> (4) Special provisions for small group health benefit plans.
>
> (a) Effective January 1, 1995, *each small employer carrier shall*, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, *offer to any individual the choice of a basic or standard health benefit plan*, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel. [Emphases added.)

It appears the Company is not in compliance with Colorado insurance law in that the Company's HMO Basic Limited Mandate Health Benefit Plan and Standard Health Benefit Plan Membership Agreements that are used for individual conversion coverage limit eligibility to applicants who live in the Company's Service Area. Eligibility for individual conversion coverage may not be limited to individuals who live in the service area. Individual conversion coverage must be offered to anyone who otherwise is eligible regardless of whether the individual lives or works in the HMO's service area.

The Company's forms state, in part:

> A. Who Is Eligible
>
> 1. General
> To be eligible to enroll and remain enrolled in these health benefit plans, you must meet the following requirements:
>
> a. You and your eligible dependents must *live* in our Service Area when you apply to enroll (our Service Area is described in the "Definitions" section); and [Emphasis added.]

Form:	Date:
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its conversion forms to reflect correct eligibility requirements as required by Colorado insurance law.

Issue E7: Failure to include all qualifying events in the special enrollment provisions of the Company's Evidence of Coverage forms.

Section 10-16-102., C.R.S., Definitions, states in part:

> (26) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:
>
> (a) The individual:
>
> (II) *Lost coverage under the other creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce,* or employer contributions towards such coverage was terminated*;* and
>
> (III) Requests enrollment within *thirty* days after termination of the other creditable coverage; or
>
> (b) *The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an open enrollment period;*
>
> (c) *A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of such court order; or*
>
> (e) *The parent or legal guardian of the dependent disenrolls the dependent from the children's basic health plan, established pursuant to article 8 of title 25.5, C.R.S., and requests enrollment of the dependent no later than ninety days after the disenrollment.* [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that the Company's reasons an eligible employee would be able to enroll outside the open enrollment period without being considered a late enrollee are very generic in its group Evidence of Coverage forms. Consequently, the forms fail to specifically include the following required qualifying events:

- Lost coverage under the other creditable coverage as a result of termination of employment or eligibility,
- Reduction in the number of hours of employment,
- The involuntary termination of the creditable coverage,
- Death of a spouse, legal separation or divorce
- Requests enrollment within *thirty* days after termination of the other creditable coverage
- The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an open enrollment period;
- A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of such court order; or

- The parent or legal guardian of the dependent disenrolls the dependent from the children's basic health plan, established pursuant to article 8 of title 25.5, C.R.S., and requests enrollment of the dependent no later than *ninety* days after the disenrollment

The Company's forms indicate the subscriber must request enrollment within *31* days of losing other coverage, which is more favorable than Colorado law which requires the subscriber to make the request within *thirty (30)* days for all events except disenrollment in the children's basic health plan. After disenrollment in the children's basic health plan, the law allows the subscriber *ninety (90)* days to make the request. The Company's forms state, in part:

4. Special Enrollment Due to Loss of Other Coverage
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within *31* days after the enrolling persons lose other coverage, if:

   a. The enrolling persons had other coverage when you previously declined Health Plan coverage for them (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason); and

   b. The loss of other coverage is due to: (i) exhaustion of COBRA coverage, or (ii) in the case of non-COBRA coverage, loss of eligibility or termination of employer contributions, but not due to cause*or individual nonpayment.

Exception: If you are enrolling yourself as a Subscriber along with at least one (1) eligible Dependent, it is necessary for only one of you to lose other coverage and only one of you to have had other coverage when you previously declined Health Plan coverage.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date your Group receives the enrollment application.

* This version of the form is present only in CLEOC-DENCOS (01/07). The other two forms have "but not cause" instead.

Form:	Date:
CLEOC-DENCOS	01/07
LGEOC-DENCOS	01/07
SGEOC-DENCOS	01/07

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to include all qualifying events that would qualify an individual to enroll outside of open enrollment to comply with Colorado insurance law.

Issue E8: Failure, in some instances, to include information in the Company's forms regarding the required offer of extending coverage for unmarried dependent children under age twenty-five.

Section 10-16-104.3, C.R.S., Dependent health coverage for persons under *twenty-five* years of age, states:

> (1) All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of part 2 of this article and *all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that offer dependent coverage shall offer to the parent, for an additional premium if applicable, by rider or supplemental policy provision, the same dependent coverage for an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102 if such child:*
>
> *(a) Has the same legal residence as the parent; or*
>
> *(b) Is financially dependent upon the parent*. [Emphases added]

It appears the Company is not in compliance with Colorado insurance law in that the Company's group membership agreement and evidence of coverage forms in some cases do not include a specific offer of coverage for unmarried dependents under age twenty-five (25) who are eligible for coverage. The language in the forms indicates that dependents are covered only up to age twenty-four (24).

The Company has provided a copy of and asserted it provides a "Dependent Verification Form" to subscribers at the time of open enrollment. However, the coverage is not needed until the dependent's twenty-fourth (24^{th}) birthday, which might be after the open enrollment period. Therefore, the subscriber may not remember the form or have it available when the coverage is needed. The Company has provided no documentation or evidence that it provides to the subscriber any additional information about the availability of this coverage or offers to provide the coverage at the time a dependent covered under the group policy reaches age twenty-four (24).

The subscriber would reasonably rely upon the membership agreement or evidence of coverage to guide him or her regarding the options available for the dependent and would therefore not know he or she could request the coverage at the time the dependent reaches age twenty-four (24).

The Company's forms state in part:

II. ELIGIBILITY AND ENROLLMENT

A. Who is Eligible

3. Dependents
   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

   a. Your Spouse.
   b. Your or your Spouse's unmarried children (including adopted children) to the end of the month of his or her *19^{th}* birthday; or, if a full-time student enrolled in an

accredited college or school who is financially dependent on you or your Spouse, to the end of the month of his or her *24*th birthday.

c. Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
   i. they are under age *19,* or if a full-time student enrolled in an accredited college or school, under age *24;* and
   ii. they receive from you or your Spouse all of their primary support and maintenance; and
   iii. they reside with you (the Subscriber); and
   iv. you or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children of any age who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. they are dependent on you or your Spouse; and
   ii. you give us proof of the Dependent's disability and dependency annually if we request it.

or

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

a. Your Spouse.
b. Your or your Spouse's unmarried children (including adopted children) who are under the dependent limiting age (or, if applicable, the dependent student limiting age) specified in the "Summary of Services Copayments and Coinsurance" section of the Appendix.
c. Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:

i. they are under the dependent limiting age (or, if applicable, the dependent student limiting age) specified in the "Summary of Services Copayments and Coinsurance" section; and
   ii. they receive from you or your Spouse all of their primary support and maintenance; and
   iii. they reside with you (the Subscriber); and
   iv. you or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children of any age who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. they are dependent on you or your Spouse; and
   ii. you give us proof of the Dependent's disability and dependency annually if we request it.

Dependent Limiting Age Requirement

The Dependent limiting age as described under Dependents in the "Eligibility and Enrollment" section is the end of the month in which age *19* is reached. An unmarried Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements.

Dependent Student Limiting Age Requirement
The Dependent limiting age as described under Dependents in the "Eligibility and Enrollment" section is the end of the month in which age *24* is reached. A full-time student in an accredited college or school, who is financially dependent on you or your spouse, will continue to be eligible until the Dependent student reaches this age, if he or she continues to meet all other eligibility requirements. [Emphases added.]

Form:	Date:
SGEOC-DENCOS	01/07
CLEOC-DENCOS	01/07

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104.3, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to include an offer of coverage to dependents under twenty-five years of age as required by Colorado insurance law.

Issue E9: Failure, in some cases, to include in the Company's forms all required elements of the entire contract provision.

Colorado Insurance Regulation 4-7-2, Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado promulgated and adopted under authority of § 10-1-109, C.R.S., states in part:

> Section 5. Requirements for Benefit Contracts and Evidences of Coverage
>
> B. Entire Contract
>
> *The contract shall contain a statement that the contract, evidence of coverage, all applications and any amendments thereto shall constitute the entire agreement between the parties.* [Emphasis added.]

It appears the Company's individual and small group contracts are not in compliance with Colorado insurance laws in that, in some instances, some elements of the required entire contract provision are not included. The Company forms state, in part:

"I. INTRODUCTION

A. **About This Individuals and Families Membership Agreement**
This **Kaiser Permanente Individuals and Families** Membership Agreement (Membership Agreement) describes the $30 Copayment Plan.

This Membership Agreement, which includes your individual application, is the legally binding contract between you, as the Subscriber, and Kaiser Foundation Health Plan of Colorado ("Heath Plan"). This is not a federally qualified health benefit plan. If you are the person who applied for Health Plan membership and agree to be responsible for payment, you are the "Subscriber". You and your enrolled Dependents are "Members". Health Plan is sometimes called "we" or "us" in this Membership Agreement. Out-of-Health Plan is sometimes referred to as "out-of-Plan."

Or

"INTRODUCTION

About this Individual Membership Agreement

This Individual Membership Agreement describes the **Kaiser Permanente HMO Basic Health Benefit Plan without Specified Mandates ("Basic") and Standard Health Benefit Plan ("Standard") for Colorado**. You have health care coverage through either the ***Basic*** or ***Standard*** Plan. These are not federally qualified health benefit plans.

This Membership Agreement (Agreement) is the legally binding contract between you, as the Subscriber, and Kaiser Foundation Health Plan of Colorado ("**Health Plan**"). If you are the person who applied for Health Plan membership and agree to be responsible for payment, you are the "**Subscriber**". You and your enrolled Dependents are "**Members**". Health Plan is sometimes called "we" or "us" in this Membership Agreement."

or

"GROUP AGREEMENT

INTRODUCTION
This Group Agreement ("*Agreement*"), including the Rate Sheet(s) attached to this Agreement, and the Evidence of Coverage ("*EOC(s)*"), all of which are incorporated into this *Agreement* by reference, and any amendments to any of them, constitute the contract between the group named on the Rate Sheet ("*Group*") and Kaiser Foundation Health Plan of Colorado ("Health Plan") In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *Evidence of Coverage* document for terms you should know. Pursuant to this *Agreement*, Health Plan will provide covered Services to Members in accord with the *Evidence of Coverage*."

Form:	Date:
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06
KPIF30-DENCOS	01-07
GA-Small-DENCOS	01/07

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to include all required elements of the entire contract provision to comply with Colorado insurance law.

Issue E10: Failure, in some cases, to provide mandated coverage for maternity care.

Section 10-16-104, C.R.S., Mandatory coverage provisions - definitions, states in part:

(3) Maternity coverage

(a)(I) *All* group sickness and accident insurance policies providing coverage within the state and issued to an employer by an entity subject to the provisions of part 2 of this article and all *group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article and issued to an employer shall insure against the expense of normal pregnancy and childbirth or provide coverage for maternity care therefor in the same manner as any other sickness, injury, disease, or condition is otherwise covered under the policy or contract.* Policies or contracts shall not exclude coverage for pregnancy and delivery expenses on the grounds that pregnancy was a preexisting condition. [Emphasis added.]

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated under authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2. Background and Scope

The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans.*

Section 4. Rules

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S.* However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.* [Emphases added.]

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. *The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or Basic HSA Limited Mandate Health Benefit Plan".*

2. *The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".*

5. *All basic and standard health benefit plans shall also comply with the following requirements:*

   G. Family Planning Services: Family planning services must be included as a covered benefit under both the basic and standard health benefit plans. *At a minimum, family planning services shall include maternity care, prenatal and postnatal care and counseling, treatment and screening as appropriate for sexually transmitted diseases, sterilization, contraceptives, and contraceptive counseling.** [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that the Company's membership agreement and evidence of coverage forms include a specific exclusion for services related to services for conception, pregnancy and delivery in connection with a surrogate arrangement. Colorado insurance law requires all group health service contracts to provide coverage for maternity care in the same manner as they provide coverage for any other sickness, injury, disease or condition. In addition, Colorado insurance law requires all basic and standard health benefit plans, which include individual conversion plans, to provide coverage for family planning services, including maternity care. Finally, Colorado insurance law does not contain any exception that would allow the Company to treat maternity services in connection with a surrogate agreement any differently than any other maternity care, including conception, pregnancy, or delivery.

The Company forms state, in part:

V. EXCLUSIONS, LIMITATIONS AND REDUCTIONS

A. Exclusions

20. **Surrogate**. Services related to conception, pregnancy, or delivery in connection with a surrogate arrangement. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.[1]

[1] Some forms have this exclusion numbered differently, as 17, 18 or a bullet instead of a number.

Form:	Date:
CLEOC-DENCOS	01/07
LGEOC-DENCOS	01/07
SGEOC-DENCOS	01/07
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S and Colorado Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to include required coverage for maternity services including when a surrogacy arrangement is involved, to comply with Colorado insurance law.

Issue E11: Failure, in some instances, to provide accurate information regarding coverage for emergency services.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part**:**

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(a) Misrepresentations and false advertising of insurance policies: *Making, issuing, circulating, or causing to be made, issued, or circulated, any* estimate, circular, *statement,* sales presentation, omission, or comparison which:

(I) *Misrepresents the benefits, advantages, conditions, or terms of any insurance policy; or*

(b) False information and advertising generally: *Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a* newspaper, magazine, or other *publication,* or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, *or in any other way,* an advertisement, announcement, or *statement containing any assertion, representation, or statemen*t with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, *which is untrue, deceptive, or misleading;* [Emphases added.]

Section 10-16-407, C.R.S., Information to enrollees, states in part:

(2) Every health maintenance organization shall *clearly state in its brochures, contracts, policy manuals, and printed materials distributed to enrollees* that such enrollees shall have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent *whenever an enrollee is confronted with a life or limb threatening emergency. For the purposes of this section, a "life or limb threatening emergency" means any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. No enrollee shall in any way be discouraged from using the local prehospital emergency medical service system, the 9-1-1 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such use in a life or limb threatening emergency.* [Emphases added.]

Section 10-16-704, C.R.S., Network adequacy – rules – legislative declaration - repeal, states in part:

(9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204(3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. *All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan.* The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan of a carrier offering a managed care plan shall demonstrate the following: [Emphasis added.]

Colorado Insurance Regulation 4-7-2, Concerning The Laws Regarding Health Maintenance Organization Benefit Contracts And Services In Colorado, promulgated under authority of 10-16-109, C.R.S., states in part:

Section 4. Definitions

C. "Emergency services" means health care services provided in connection with any event that *a prudent lay person would believe threatens his or her life or limb* in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Section 5. Requirements for Benefit Contracts and Evidences of Coverage

E. Emergency Care Services

The contract and/or evidence of coverage *shall contain a specific description of emergency services* available twenty-four hours a day, seven days a week, *including disclosure of how emergency care services will be accessible within the HMO's service area by affiliated providers and nonaffiliated providers.*

It appears that the Company is not in compliance with Colorado insurance law in that its membership agreement and evidence of coverage forms contain emergency services provisions that:

- are misleading and appear to discourage use of the nearest emergency facility by indicating members will be directed to plan facilities if they call the Health Plan and state that any hospital which has contracted for Emergency Services will be listed in the plan directory or below that section of the form.

- are misleading in that they include an incorrect definition and language stating emergency services provided, arranged, or authorized in advance are covered, and appear to indicate the need for emergency services could be scheduled and should be authorized in advance.

The Company's forms state in part[1]:

H. Emergency Services and Non-Emergency, Non-routine Care

1. Emergency Services

"Emergency Services" means health care Services provided in connection with an event that you reasonably believe threatens your life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. ***Emergency Services are available from Plan Hospitals at all times***[2] – 24 HOURS A DAY, 7 DAYS A WEEK.

This provision is misleading and discourages use of the nearest emergency facility by indicating emergency services are available from plan hospitals at all times without mentioning in that section that members may go to the nearest emergency facility for an emergency. Colorado insurance law does not permit limiting Emergency Services coverage to services provided in plan hospitals or the nearest contracted facilities or discouraging use of the nearest emergency facility in an emergency.[3]

a. Emergency Services Provided By Plan Providers

i. ***Denver/Boulder*** Service Area

If you are not sure whether your situation is an emergency, call **303-338-4545** for advice, 24 hours a day, 7 days a week. Deaf, hard of hearing, or speech impaired Members who use TTY may call **303-338-4428.** If an ambulance is necessary, we will authorize it.

When you call, we may tell you to go directly to the emergency room of ***a Plan Hospital or to our nearest contracted facility***. If an ambulance is Medically Necessary, we will authorize it. If your condition warrants immediate medical attention to prevent death or serious impairment of health, you should seek care immediately by calling **911** ***or by going to one of our Plan Hospitals listed in our provider directory.*** Please see "Plan Facilities" under "How to Obtain Services" to obtain a copy of the provider directory.

ii. ***Colorado Springs*** Service Area

If you are not sure whether your situation is an emergency, you may call your plan physician for direction. Your Plan Physician or an on-call designee is available 24 hours a day, 7 days a week.

If it is determined that your situation warrants immediate medical attention to prevent death or serious impairment of health, you may seek care immediately by calling **911** or ***by going to the Plan Hospital(s) listed in our provider directory***. Please see "Plan Facilities" under "How to Obtain Services" to obtain a copy of the Affiliated Practitioner Directory.

These provisions are misleading and discourage use of the nearest emergency facility by stating only that the member may go to the nearest plan hospital without also stating that the member may go to the nearest emergency facility, whether or not that facility is a plan hospital or contracted facility.

b. Emergency Services Provided by non-Plan Providers (out-of-plan Emergency Services)
"Out-of-Plan Emergency Services" are Emergency Services that are not provided or authorized in advance by a Plan Physician. There may be times when you or a family member may receive Emergency Services from non-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Medical Offices or the emergency room of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

This provision is misleading in that it gives the impression some emergency services are authorized in advance and thereby raises the question of whether emergency services not provided or authorized in advance by plan physicians are covered. The nature of an emergency service as defined in Colorado insurance law precludes advance knowledge to request authorization. Therefore, authorization in advance is not required for any emergency services, whether inside the service area or in-plan or outside of service area or out-of-plan. The word "authorized" appears to preclude the member independently making the decision regarding whether the situation is an emergency, the subsequent sentences not withstanding.

Please refer to "iii. Emergency Services Limitation for non-Plan Providers," below, if you are hospitalized for Emergency Services.

i. ***Denver/Boulder*** Service Area
In the ***Denver/Boulder*** Service Area, ***any hospitals we have contracted with for Emergency Services will be listed in the provider directory***. Please see "Plan Facilities" under "How to Obtain Services" to obtain a copy of the provider directory.

This provision is misleading and discourages use of the nearest emergency facility by not stating that members may go to the nearest emergency facility for emergency services, whether or not that facility is a hospital with which the plan has contracted for emergency services.

Please refer to "iii. Emergency Services Limitation for non-Plan Providers," below, if you are hospitalized for Emergency Services.

ii. We cover out-of-Plan Emergency Services as follows:
A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, ***such as myocardial infarction, appendicitis or premature delivery.***[3]

Listing without clarifying that the list is not the exclusive or exhaustive list of events that are covered for emergency services, the provisions are misleading and appear to be limiting emergency services coverage to the listed events.

Form:	**Date:**
INDBS-NFQ-DENCOS	01/06
INDBS-NFQ-DENCOS	07/07
SGEOC-DENCOS	01/07
KPIF30-DENCOS	01/07
CLEOC-DENCOS	01/07

[1] The form quoted is CLEOC-DENCOS (01/07). There are some verbiage differences among the individual forms, with the greatest difference noted in the (01/06) version of INDBS-NFQ-DENCOS, which lists specific in-plan providers to which members are directed for emergency services, but the provisions are essentially the same in all forms.
[2] Examiner's emphases in Company's provisions quoted above are indicated by text that is italicized, bold and underlined.
3 Examiner's comments are interspersed with the provisions quoted and are flush with the left margin.

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, 10-16-407 and 10-16-704, C.R.S. and Colorado Insurance Regulation 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to provide accurate information regarding coverage for emergency services to comply with Colorado insurance law.

Issue E12: Failure to include the required form and content in the Basic and Standard health benefit plan forms.

Section 10-16-107, C.R.S., Rate regulation - rules - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees - disclosures on treatment of intractable pain, states in part:

(3)(b) An evidence of coverage shall contain:

(I) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in section 10-16-413 (1); and

(II) A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

(A) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan, including the ability to obtain a second opinion for proposed treatment by the health care provider, if the health benefit plan provides such coverage;

(B) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(C) Where and in what manner information is available as to how services may be obtained;

(D) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates;

(E) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

Section 10-16-413, C.R.S., Prohibited practices, states in part:

(1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or *any form of evidence of coverage* which is deceptive. For purposes of part 1 of this article and this part 4:

(a) A statement or item of information is deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.

(b) A statement or item of information is deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement

is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

(c) An evidence of coverage is deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.
[Emphases added.]

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated under authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 2. Background and Purpose

The purpose of this amendment to Colorado Insurance Regulation 4-6-5 is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard plans and to incorporate other changes necessary for compliance with Colorado law. *This regulation specifies the requirements for the basic and standard health benefit plans.*

Section 4 Rules

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options,* two of which are high deductible, HSA-qualified plan options, *shall be required for use* in Colorado's small group market pursuant to §10-16-105(7.3), C.R.S., and *as conversion coverage pursuant to §10-16-108, C.R.S.* However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.*

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. *The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2) (b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or Basic HSA Limited Mandate Health Benefit Plan".*

2. *The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".*

It appears the Company is not in compliance with Colorado insurance law in that its basic and standard membership agreement and evidence of coverage forms in some cases do not provide benefits in the required form and content. Some required benefits are included in the forms, but are listed under headings other than the specific benefit headings required in Regulation 4-6-5. In some instances, required coverages appear to be excluded due to the Company combining the basic and standard forms into one document, and the inclusion of a required basic benefit and an excluded basic benefit under one heading. In some instances, other benefits that the Company has asserted are provided are not listed in the forms. Therefore, there is no evidence in these forms that the benefits are provided.

The Company has advised that no summary of benefits is provided to members along with the membership agreement or evidence of coverage forms. The tables of contents also don't list the required benefits because the benefits are not identified with their own headings. The lack of required headings complicates and hinders members' ability to locate a particular benefit or benefit exclusion. This creates the potential to cause a reasonable person without special knowledge of health care coverage to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees to be covered under such evidence of coverage. This potential exists even without considering the combining of the basic and standard plans in one form.

Some specific issues identified by the examiners are:

- Routine Medical Care is listed under Outpatient Care instead of under its own heading,

The Company's form SGEOC-DENCOS (01/07)** states, in part:

A. Outpatient Care
STANDARD: $25 each *primary care visit*; $40 each *specialty care visit*; $25 each *preventive care visit*
BASIC: $40 each *primary care visit*; $80 each *specialty care visit*; $40 each *preventive care visit*

Outpatient Care for *Preventive Care*, Diagnosis and Treatment
We cover, only as described under this "Benefits" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following

outpatient care for preventive care, diagnosis and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility or at home:

1. *Primary care visits*: Services from family medicine, internal medicine and pediatrics
2. *Specialty care visits*: Services from providers that are not primary care, as defined above. [Emphases added.]

The italicized benefits should be listed under the heading "Routine Medical Office Visits".

- Maternity Care is listed under Outpatient Care instead of under the specific heading of "Maternity",

The Company's form SGEOC-DENCOS (01/07)** states, in part:

3. *Prenatal and postpartum visits.* [Emphases added.]

These should be listed under the heading "Maternity".

- Outpatient Ambulatory Surgery is listed under Outpatient Care instead of under its own heading,

The Company's form SGEOC-DENCOS (01/07)** states, in part:

6. *Outpatient surgery at designated outpatient facilities, consisting of all physicians' facility Services and supplies.* [Emphases added.]

This should be listed under the heading "Outpatient/Ambulatory Surgery".

- Spinal Manipulation is listed under Outpatient Care instead of as a benefit or exclusion under Significant Additional Services,

The Company's form SGEOC-DENCOS (01/07)** states, in part:

11. *Spinal manipulation* [Emphases added.]

This should be listed under the heading "Significant Additional Services".

- Preventive care Services are listed under Outpatient Care instead of under its own heading.

The Company's form SGEOC-DENCOS (01/07)** states, in part:

12. *Preventive care* Services which include:
    a. *Health maintenance visits*
    b. Well child and well baby visits
    c. Immunization visits
    d. Routine screenings such as blood cholesterol, colorectal cancer screening, and pap smears
    *e. Screening mammograms and clinical breast exams (**covered under Standard Plan only; excluded in Basic Plan*)***
    *f. Prostate screening (**coverage under Standard Plan only, excluded in Basic Plan*)*** [Italicized emphases added.]

*Please see the attached benefit description following the Appendix for additional coverage if applicable.

Although these do have their own heading as number 12. under "Outpatient care" they should be listed under their own heading "Preventive Care" as above and Attachment 1 should be attached to the form.

- Obstetrical Care and Delivery are listed under Hospital Inpatient Care instead of under the heading of "Maternity",

The Company's form SGEOC-DENCOS (01/07)** states, in part:

B. Hospital Inpatient Care
STANDARD:$250 each day, up to $1,000 maximum per admission
BASIC: $500 each day, up to a $2, 000 maximum per admission

1. Inpatient Services in a Plan Hospital
We cover, only as described under this "Benefits" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Areas:

e. *Obstetrical care and delivery (including Cesarean section). Note: If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Physician may order a follow-up visit for your and your newborn to take place within 48 hours after discharge. If your newborn remains hospitalized following your discharge, you will be required to pay a separate hospital Copayment for your newborn.*

g. Other hospital Services and supplies, such as:
i. Operating, recovery, *maternity* and other treatment rooms [Emphases added.]

Inpatient Hospital, Obstetrical care and maternity should be under the headings of “Inpatient Hospital” and "Maternity".

- Oxygen is listed under Hospital Inpatient Care in a list of medical supplies and in a paragraph under Durable Medical Equipment instead of under the heading of "Oxygen",

The Company's form SGEOC-DENCOS (01/07)** states, in part:

vii. Medical supplies, appliances, medical equipment, including *oxygen*, and any covered items billed by a hospital for use at home. [Emphases added.]

Oxygen should be under the heading "Oxygen". There is no prohibition to including oxygen exclusion in other places in the form but the excluded benefit must also have the required stand-alone heading.

- Alcohol and Substance Abuse has its own heading but the heading is Chemical Dependency instead of Alcohol and Substance Abuse,

The Company's form SGEOC-DENCOS (01/07)** states, in part:

D. *Chemical Dependency Services*
Standard: 50% of charges
Basic: Not covered

This correctly has its own heading and is therefore listed in the table of contents, but the heading is not the required heading "Alcohol and Substance Abuse". [Emphases added.]

- Prescription Drugs is listed under Drugs, Supplies and Supplements instead of under the heading "Prescription Drugs",

The Company's form SGEOC-DENCOS (01/07)** states, in part:

F. *Drugs, Supplies and Supplement*

1. Coverage
   a. Outpatient *Prescription Drugs* or Refills

2. *Drugs,* Supplies and Supplements Limitations:
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.

3. *Drugs,* Supplies and Supplements Exclusions:
   c. *Denver Boulder Service Area: Non-preferred drugs, unless a non-preferred drug has been specifically prescribed and authorized through the non-preferred drug process,*
   e. *Drugs or injections for treatment of sexual dysfunction disorders.*
   k. *Drugs used in the treatment of weight control.* [Emphases added.]

This should be under the heading "Prescription Drugs". In addition, the required prescription drug benefit includes non-preferred drugs with a higher coinsurance amount. The Company may not therefore exclude coverage for non-preferred drugs unless authorized through a specific process.

- Biologically Based Mental Illness Care, Other Mental Health Care (Basic) and Other Mental Health Care (Standard) are all listed under Mental Health Services. Not only are these benefits not listed under their own headings but inclusion of Biologically Based Mental Illness under an incorrect heading a appears to exclude this required coverage,

The Company's form SGEOC-DENCOS (01/07)** states, in part:

N. *Mental Health Services*

1. Coverage
   We Cover mental health Services as specified below, including evaluation and Services or conditions which, in the judgment of a Plan Physician, would be responsive to therapeutic management.

   a. Outpatient Therapy

STANDARD: 50% of Charges, up to 20 visits or $1,500 per calendar year, whichever is greater.
BASIC: Not Covered

b. Inpatient Services
STANDARD: 50% of Charges, up to 45 inpatient days or 90 partial days per calendar year.
BASIC: Not Covered

d. *Treatment for Biologically-Based Mental Health Conditions*
Treatment for six (6) specific mental health diagnoses are covered the same as any other illness, injury, or disease. These diagnoses are: schizophrenia, schizoaffective disorder, specific obsessive compulsive disorder, major depressive disorder, bipolar affective disorder and panic disorder. Your outpatient medical care Copayment applies for outpatient treatment and your hospital inpatient care Copayment applies for inpatient treatment. [Emphases added.]

Coverage for Mental Health Services should be separated into two benefits, one with the heading "Biologically Based Mental Illness Care" and one with the heading "Other Mental Health Care" because biologically based mental health care is covered under both basic and standard health benefit plans in the same way any other physical illness under that plan is covered.

2. *Mental Health Services Exclusions*
g. *Services for Members enrolled in **Basic Plan.*** [Emphases added.]

Treatment for biologically based mental illness care is a required benefit for members under a basic health benefit plan and the location of this exclusion under an incorrect heading appears to exclude that benefit. The additional language under N.1.d. and N.2.g. do not indicate an exception to this overall exclusion.

- Organ Transplant is listed under Transplant Services instead of under its own heading and omits coverage for a required transplant coverage, peripheral stem cell support,

The Company's form SGEOC-DENCOS (01/07)** states, in part:

R. *Transplant Services*
STANDARD/BASIC: Copayment for hospital inpatient applies

1. Coverage
Transplants are covered on a **LIMITED** basis as follows:
a. Covered transplants are limited to kidney transplants, heart transplants, heart-lung transplants, liver transplants, lung transplants, cornea transplants, and simultaneous kidney-pancreas transplants.
b Bone marrow transplants (autologous stem cell or allogenic stem cell) for Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease neuroblastoma, lymphoma, high risk stage II and III breast cancel and Wiskott-Aldrich syndrome.

This should be under the heading "Organ Transplants". In addition, the form does not include the required sentence: "Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants." [Emphases added.]

- Chiropractic Care is listed under Exclusions instead of under its own heading. The exclusion is misleading because the Standard form refers to Significant Additional Services where Spinal Manipulation is a covered benefit,

The Company's form SGEOC-DENCOS (01/07)** states, in part:

A. Exclusions
The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits" section.

1. **Alternative Medical Services**. Acupuncture Services, naturopathy Services, massage therapy, chiropractic Services and Services of *chiropractors*. [Emphases added.]

Chiropractic care, even when excluded, should be listed under the heading "Chiropractic Care".

- The "What Treatments and Conditions are Excluded Under This Policy?" heading is omitted and the treatments and conditions excluded are listed under Exclusions instead of under this heading. Bariatric Surgery is listed as a specific and limited exclusion instead of the exclusion for "charges related to the surgical treatment of obesity". Several excluded treatments and conditions are not listed and are therefore not excluded by the Company's forms, providing coverage enhanced above the basic and standard coverage without the required rider or endorsement. These are: educational training problems, learning disorders, sexual dysfunction and war. Some exclusions, such as marital and social counseling, sexual dysfunction and treatments not medically necessary, are included as exceptions under other benefits or sections of the forms. However, there is no general exclusion of these benefits or treatments under the required heading,

The Company's form SGEOC-DENCOS (01/07)** states, in part:

2. ***Bariatric Surgery and Cosmetic Surgery Related to Bariatric Surgery***
[Emphases added.]

The language of the required exclusion is: "charges related to the surgical treatment of obesity". Cosmetic care of any kind is excluded.

Additional treatments and conditions that are excluded from the basic and standard health benefit plans that do not appear to be excluded in the Company's exclusion section of the forms are: educational training problems, learning disorders, sexual dysfunction and war. Some exclusions, such as marital and social counseling, sexual dysfunction and treatments not medically necessary, are included as exceptions under other benefits or sections of the forms. However, there is no general exclusion of these benefits or treatments under the required heading.

- Out of Pocket Maximum is listed in the Appendix under Limitations on Copayments instead of under its own heading.

The Company's form SGEOC-DENCOS (01/07)** states, in part:

> The following terms, when capitalized and used in any part of the EOC, mean:
>
> ***Out-of-Pocket Maximum**:* The annual limit to the total amount of Copayments you must pay in a year for covered Services (see "Limit on Copayments (Annual Out-of Pocket Maximum)" in the "Appendix" section.)
>
> **X. APPENDIX**
>
> E. ***Limit on Copayments (The Annual Out-of-Pocket Maximum)***
> You are not required to pay more than the Copayment limits listed below for certain covered Services during each calendar year.
>
> The Copayments paid by different family members cannot be combined to have one member certified as having met the Copayment limit applicable to each member.
>
> The Copayments limit is $3,000 per individual or $6,000 per family each calendar year **(Standard Plan)**; $6.000 per individual or $12,000 per family each calendar year (Basic Plan). [Emphases added.]

There is no prohibition to listing Out-of-Pocket Annual Maximum under the Appendix. However, the Company must also list this benefit under the heading "Out-of-Pocket Annual Maximum".

- Annual Deductible and Lifetime or Benefit Maximum Paid by Plan for all Care are not listed, defined or otherwise included in the forms. Each should be included under its own heading. While the first statement under "Limit on Copayments (Annual Out-of-Pocket Maximum)" in the Appendix references the amount paid for certain covered services, no reference to a deductible is included. These headings and the information provided under them are required and the Company must include them, indicating there is no annual deductible and no lifetime maximum benefit paid for all care.

- Period During Which Pre-existing Conditions are not Covered, Exclusionary Riders, and How Does the Policy Define "Pre-existing Condition"? provisions are not included and there is no heading regarding pre-existing conditions, no definition of pre-existing conditions, and no indication that the plans do not impose a limitation for pre-existing conditions, which is the required HMO benefit. These are not specifically addressed in the forms and should be included with the appropriate headings.

Form:	Date:
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06
SGEOC-DENCOS	01/07

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-107 and 10-16-413, C.R.S. and Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its Basic and Standard plan forms to reflect the required form and content as required by Colorado insurance law.

Issue E13: Failure to include information regarding payment of claims that complies with Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims - legislative declaration, states in part,

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request.* Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that its membership agreement and evidence of coverage forms include a provision to simply return incomplete claims forms for out-of-plan services or services from non-plan providers to the covered person. The forms do not indicate whether the claims are pended for receipt of the missing information, as required, or denied when the incomplete claims forms are returned to the covered person.

The Company's forms state in part:

VI. FILING CLAIMS AND MEMBER SATISFACTION PROCEDURE

A. Filing Claims

1. Post-Service Claims and Appeals

Post-Service claims are requests for payment for Services you already received, including claims for out-of-Plan Emergency Services. If you have any questions about post-Service claims or appeals,…

a. Procedure for Making a Post-Service Claim

Claims for out-of-Plan Emergency Services, out-of-Plan non-emergency, non-routine care or other health care Services received from non-Plan Providers must be filed on forms provided by Health Plan.

In the ***Denver/Boulder*** Service Area, forms may be obtained by calling or writing to:…

You must send the completed claim form to us within 180 days after you receive out-of-Plan Services or Services from non-Plan Providers. Attach itemized bills along with receipts if you have paid the bills. Return the completed claims to the address listed on the claim form. *Incomplete claim forms will be returned to you.* This will delay any allowed payments. Also, you must complete and submit to us any documents that we may reasonably request for processing your claim or obtaining payment from insurance companies. We will review your claim, and if we have all the information we need, we will send you a written decision within 30 days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we tell you we need more time and ask you for more information, you will have 45 days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will make a decision based on the information we have. *We will issue our decision within* 15 days of our receipt of the additional information, or if no information is received, within 15 days of the deadline for receiving the information. [Emphases added.]

If we deny your claim (if we do not pay for all the Services you requested), our written decision will tell you why we denied your claim and how you can appeal.

or, in another version:

Filing Claims

Post-Service Claims and Appeals

Post-Service claims are requests for payment for Services you already received, including claims for out-of-Plan Emergency Services. If you have any questions about post-Service claims or appeals,…

Procedure for making a post-Service Claim

1. Claims for out-of-Plan emergency, out-of-Plan non-emergency, non-routine care or other health care Services received from non-Plan Providers must be filed on forms provided by Health Plan and may be obtained by calling or writing to:…

You must send the completed claim form to us within 180 days after you receive out-of-Plan Services or Services from non-Plan Providers. Attach itemized bills along with receipts if you have paid the bills. Return the completed claims to the address listed on the claim form. *Incomplete claim forms will be returned to you.* This will delay any allowed payments. Also, you

must complete and submit to us any documents that we may reasonably request for processing your claim or obtaining payment from insurance companies.

2. We will review your claim, and if we have all the information we need, we will send you a written decision within 30 days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we tell you we need more time and ask you for more information, you will have 45 days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will make a decision based on the information we have. We will issue our decision within 15 days of our receipt of the additional information, or if no information is received, within 15 days of the deadline for receiving the information. [Emphases added.]

3. If we deny your claim (if we do not pay for all the Services you requested), our written decision will tell you why we denied your claim and how you can appeal.

Form:	Date:
SGEOC-DENCOS	01/07
CLEOC-DENCOS	01/07
LGEOC-DENCOS	01/07
INDBS-NFQ-DENCOS	07/07
INDBS-NFQ-DENCOS	01/06
KPIF30-DENCOS	01-07

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to include correct information regarding payment of claims to comply with Colorado insurance law.

Issue E14: Failure, in some instances, to provide accurate information regarding tracking of member co-payments and out-of-pocket maximums. *(This was prior issue E3 in the market conduct examination report dated December 31, 1996.)*

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonability clear; or
>
> (XVII) Failing to adopt and implement reasonable standards for the prompt resolution of medical payment claims.

It appears that the Company is not in compliance with Colorado insurance law in that its policy forms, in some cases, require that Member(s) keep track of payment of their co-payments and notify the Company when they have reached the co-payment maximum set forth in their contract.

It is the Division's position that this requirement forces the Member(s) to provide information that the Company should already be maintaining or aware of. It is the Company that has the primary responsibility to maintain the records relating to co-payments and when the maximums have been reached in order to properly adjudicate claims. This requirement places the Member(s) in an adversarial position that may lead to delays and/or improper payment in the settlement of claim liability, or termination of coverage for cause in the case of unpaid co-payments.

The examiners recognize that it is in the Member's best interest to keep a record of their out-of-pocket expenses in order to ensure that they are receiving correct benefit payment, however, as the maximum out-of-pocket expenditure is a contractual provision, it is the Company's responsibility to administer it accurately.

The Company's membership agreements state the following:

APPENDIX

Limits on Copayments (Annual Out-of-Pocket Maximums)

You are not required to pay more than the Copayment limits listed below for certain covered Services during each year. *When you pay a copayment for these Services, it is important to ask for and keep the receipts. When the receipts add up to the annual Copayment limit, call our Patient Business Services Department at 303-743-5900. We will verify whether the limit has been met and, if so, issue a "Waiver Card" in the family member's name who has met the limit, along with a letter explaining how to use the card*. This Waiver Card will show that you do not have to pay any more Copayments for the specified Services for the remainder of the year. Your exemption from further payment of Copayments is effective from the date the limit is reached until the end of the year in which the

exemption occurred. We will refund any Copayments paid by you between the time the Copayment limit is reached and the date your Waiver Card is issued. [Emphasis added.]

Form	Form Number
INDBS-NFQ-DENCOS	01/06

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to provide accurate information regarding tracking of member copayments and out-of-pocket maximums to comply with Colorado insurance law.

In the market conduct examination for the period January 1, 1996 to December 31, 1996, the Company was cited for its policy forms containing language that restricts exemption from further payment of copays and other supplemental charges for the remainder of the calendar year until the date the member presents proof of attaining the out-of-pocket limit. The violation resulted in Recommendation #4 of Final Agency Order O-98-62 that the Company provide documentation of correction of this language. Failure to comply with the previous order of the commissioner may constitute a violation of § 10-1-205, C.R.S.

Issue E15 Failure, in some cases, to file and certify compliance of forms prior to their use.

Section 10-16-107.2., C.R.S, Filing of health policies states in part:

> (2)(a) *All* sickness and accident insurers, *health maintenance organizations,* nonprofit hospital and health service corporations, and other entities providing health care coverage authorized by the commissioner to conduct business in Colorado *shall also submit to the commissioner a list of any new policy form, application, endorsement, or rider at least thirty-one days before using such policy form, application, endorsement, or rider for any health coverage.* Such listing shall also contain a certification by an officer of the organization that each new policy form, application, endorsement, or rider proposed to be used complies, to the best of the insurer's good faith knowledge and belief, with Colorado law. The necessary elements of the certification shall be determined by the commissioner. [Emphases added.]

UNCERTIFIED FORMS USED IN 2007

Population	Sample Size	Number of Exceptions	Percentage to Sample
7,165	100	58	58%

It appears the Company is not in compliance with Colorado insurance law in that it used five (5) individual health plan application forms in 2007 that were not included on the list of new forms for health coverage certified with the Division in 2007. Four (4) of the application forms were included on the list certified in 2008 and one (1) has not yet been included. Three (3) application forms had no identifying form numbers. The examiners were unable to determine whether those application forms had been included. Therefore, those three (3) are included in the list of applications submitted on forms not certified.

Fifty-eight (58) of the 100 application files randomly selected from the 7,165 individual applications in the total population of individual applications were submitted on unfiled forms including the three (3) with no form numbers. The Company explained that the one form was not certified because it was the same as one of the other uncertified forms in use and was assigned a separate number in error. That application form was used to submit twenty-five (25) of the 100 individual applications in the sample.

Form	Number Applications
32619/CO/February 2007	14
32620/CO/2007	2
34192/CO May 2007	10
34194/CO May 2007	25
60015907/CO Nov 2007 Ex	4
No Form Number Provided	3
Total number of sample applications submitted on unfiled forms	58

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-107.2 C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that a list of all new forms is provided to the Division and certified by an officer of the Company to be in compliance with Colorado insurance laws prior to their use as required by Colorado insurance law.

NEW BUSINESS APPLICATIONS AND RENEWALS

Issue G1: Failure to ensure all applicants for individual coverage complete the "Determination of Self-Employed Business Group of One Form." *(This was a partial repeat of prior issue G1 in the market conduct examination report dated December 31, 2001.*

Section 10-16-105.2, C.R.S., Small employer health insurance availability program states in part:

(1)(c)(I) The provisions of this article concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor *if, pursuant to rules adopted by the commissioner, all of the following conditions are met:*

(A) As part of the application process, the carrier determines whether or not the applicant is a self-employed person who meets the definition of a business group of one pursuant to section 10-16-102 (6).

(B) If the applicant is a business group of one self-employed person, the carrier accepts or rejects such person and, if such person is applying for family coverage, accepts or rejects the entire family unless the applicant waives coverage for a family member who has other coverage in effect.

(C) If the carrier rejects an application for a business group of one self-employed person and the carrier does business in both the individual and small group markets, the carrier shall notify the applicant of the availability of coverage through the small group market and of the availability of small group coverage through the carrier.

(D) *As part of its application form, an individual carrier requires a business group of one self-employed person purchasing an individual health benefit plan pursuant to this subparagraph (I) to read and sign a disclosure form* stating that, by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be his or her right to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three years after the date the individual health benefit plan is purchased, unless a small employer carrier voluntarily permits such person to purchase a business group of one policy within such three-year period. The disclosure form shall also briefly describe the factors used to set rates for the individual policy being purchased in comparison with the factors used to set rates for a business group of one small group policy. The individual carrier shall provide to the business group of one self-employed applicant a copy of the health benefit plan description form for the Colorado standard health benefit plan in addition to the

> description form for the individual plan being marketed. The disclosure form may be included within any other certification form that the carrier uses for the plan. The division of insurance shall make available a standard plan description form to individual carriers upon request. [Emphases added.]

Colorado Insurance Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups of One., promulgated pursuant to Sections 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S. states in part:

> Section 5. Rules
>
> A. An individual health benefit plan Marketed and/or newly issued on or after October 1, 2004, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself and the application for coverage meet all the following conditions:
>
> 1. Pursuant to Section 10-16-105.2(1)(c)(1)(A), C.R.S., the carrier issuing the policy determines whether or not the applicant is a self-employed business group of one. A carrier shall meet this requirement by having all applicants fill out the "Determination of Self-Employed Business Group of One Form" available from the Colorado Division of Insurance. *A copy of the completed form shall be kept on file with each application.* …
>
> 4. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in Section 10-16-105.2(1)(c)(I)(D), C.R.S. Accordingly:
>
> a) *The carrier, as part of its application form, shall require each self-employed business group of one purchasing an individual health benefit plan pursuant to Section 10-16-105.2(1)(c)(I) to read and sign a disclosure form*, as proscribed by the Division of Insurance, attesting that they understand that they are forfeiting their rights to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three(3) years after the date of the purchase, unless a small employer carrier voluntarily permits the purchase of a business group of one policy within that three-year period.
>
> b) The carrier must provide the applicant with a Colorado Health Plan Description Form for the state's Standard Health Benefit Plans, available from the Colorado Division of Insurance. Carriers may reproduce and distribute this form in order to comply with the provisions of Section 10-16-105.2(1)(c)(1)(D), C.R.S.

B. Material failure by a carrier or its representative to comply with the requirements of Part A of Section 5 of this regulation will result in individual policies sold to self-employed business group of one becoming subject to Colorado's small group laws. [Emphases added.]

INDIVIDUAL NEW BUSINESS APPLICATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
7,165	100	14	14%

It appears the Company is not in compliance with Colorado insurance law in that fourteen (14) of the 100 sample applications reviewed did not have completed Business Group of One Determination Forms attached. The files with missing information included:

One (1) file in which the Determination of Self-Employed Business Group of One Form was included but the questions were not answered,

Two (2) files in which the application form used did not include the Determination of Self-Employed Business Group of One Form, so the questions were not asked of the individual applicant,

(These three files are a repeat of issue G1 in the prior market conduct examination report dated December 31, 2001.)

One (1) file for which the Company submitted a second application to the examiners had the Determination of Self-Employed Business Group of One Form questions answered "no", contrary to the answers in the application initially provided. The submission dates were the same and the examiner could not determine which application contained the correct answers to the questions so this file was retained as having a "yes" answer but without the required signatures.

Ten (10) other files that had affirmative answers to the Determination of Self-Employed Business Group of One Form questions but no signatures on the disclosure and acceptance forms.

The Company stated in an email dated 12/2/2008, that to complete processing, the electronic application process requires the answers to the questions and the electronic signing of the Determination of Self-Employed Business Group of One Form and the disclosure form when applicable. Although this is required, the Company asserted, the electronic application file doesn't retain those signatures and copies with signatures cannot be produced. Colorado insurance law requires that a copy of the completed form must be retained in the application file. A form is not complete without the required signatures.

It should be noted that:

- The Company signature requirement failed in one (1) of the 100 files reviewed because the electronic application processed without the answers to the questions in the Determination of Self-Employed Business Group of One Form and

- Four (4) of the 100 individual applications reviewed included e-signatures.

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-105.2, C.R.S., and Colorado Insurance Regulation 4-2-19. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that Business Group of One Determination Forms are completed and signed by each applicant applying for individual coverage, and are retained in the files as required by Colorado insurance law.

CANCELLATIONS/DECLINATIONS/TERMINATIONS

Issue H1: Failure of the Company's CoverColorado Notice Form to contain all required disclosure elements.

Colorado Insurance Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form and Eligibility Requirements, promulgated pursuant to §§10-1-109 and 10-8-520, states in part:

Section 4 Rules

B. Notification Requirements for Individuals with Adverse Underwriting Decisions

2. The carrier shall attach a copy of the CoverColorado Program Notice Form to the notice of adverse underwriting determination listed above. *Carriers* may print the CoverColorado Notice Form on their own stationary but *shall use the order, format and content of the CoverColorado Notice Form as prescribed by the Commissioner of Insurance*.

C. Elements of the CoverColorado Notice Form for Adverse Underwriting Decisions

6. *Name and telephone number of underwriter or other contact at the carrier's office.* [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that its CoverColorado Notice Form provided to applicants who are subject to an adverse underwriting decision fails to provide the name and telephone number of the underwriter or other contact at the carrier's office.

Additionally, the examiners note the Company's CoverColorado Notice Form also does not reflect the changes outlined in Bulletin No. B-4.8, reissued May 8, 2007 that provides that carriers disclose the website and e-mail address of CoverColorado.

Form	Form Number
CoverColorado Plan Notice Form	No form number

Recommendation 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado insurance regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its CoverColorado Notice Form to comply with Colorado insurance law.

Issue H2: Failure, in some instances, to provide a written notice of declination and/or not providing sufficient written detail as to the reason for denial of coverage.

Section 10-16-108.5, C.R.S., Fair Marketing Standards, states in part:

> (7) *Any denial by a carrier of an application for coverage from an individual* or a small employer *shall be in writing* and *shall state any reason for the denial*. [Emphasis added.]

INDIVIDUAL NEW BUSINESS APPLICATIONS DENIED

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,500	50	4	8%

It appears the Company is not in compliance with Colorado insurance law in that, in some cases, it failed to provide a written notice of denial or sufficient reason for the denial to applicants who are subject to an adverse underwriting decision.

The examiners reviewed a sample of fifty (50) individual new business applications from a total population of 4,500 that were denied. In four (4) of the fifty (50) files reviewed, the examiners were unable to locate either a written notice of denial sent to the applicants or a notification that detailed the reasons for the denial. In two (2) instances, the files did not contain any written notification of denial and in another two (2) instances; the written notification of denial did not contain the specific reason for the denial of coverage.

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-108.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notice of the reason(s) for denial of coverage is provided to all denied applicants to comply with Colorado insurance law.

Issue H3: Failure, in some instances, to provide written notice of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan.

Section 10-16-105.2, C.R.S., Small employer health insurance availability program, states in part the following:

> (c) (I) The provision of this article concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole-proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:
>
> *(A) As part of the application process, the carrier determines whether or not the applicant is a self-employed person who meets the definition of a business group of one pursuant to section 10-16-102 (6).*
> (B) If the applicant is a business group of one self-employed person, the carrier accepts or rejects such person and, if such person is applying for family coverage, accepts or rejects the entire family unless the applicant waives coverage for a family member who has other coverage in effect.
> (C) *If the carrier rejects an application from a business group of one self-employed person and the carrier does business in both the individual and small group markets, the carrier shall notify the applicant of the availability of coverage through the small group market and of the availability of small group coverage through the carrier*. [Emphasis added]

Colorado Insurance Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to §§ 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8) and 10-16-109, C.R.S., states in part:

> 5. Rules
>
> A. An individual health benefit plan marketed and/or newly issued on or after October 1, 2004, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all of the following conditions:
>
> 2. Pursuant to Section 10-16-105.2(1)(c)(I)(B), C.R.S., the carrier issuing the individual health benefit plan accepts or rejects a self-employed business group of one who applies for coverage and, if such person is applying for family coverage, his/her entire family (all dependents), unless the applicant waives coverage for a family member who has other coverage in effect. A carrier shall meet this family coverage requirement by:

a) Asking each self-employed business group of one applicant requesting coverage for himself/herself and one or more dependents for the names of all his/her dependents;

b) Where the applicant waives coverage for a family member, keeping on file with the application a signed statement from the applicant that he/she is waiving coverage for a dependent because that person already has other coverage in effect and shall state what that coverage is and when it became effective; and

c) Where a self-employed business group of one is rejected for individual coverage because one or more family members fail to meet normal and actuarial-based underwriting criteria, the carrier shall clearly state this as part of the reason for denial and shall notify the applicant in writing of the availability of coverage for his/her whole family under a small group policy.

3. If, pursuant to Section 5.A.2 of this regulation, a carrier rejects an application by a self-employed business group of one for coverage under an individual plan, and if that same carrier sells coverage in both the individual and small group markets, then pursuant to Section 10-16-105.2(1)(c)(I)(C), C.R.S., *the carrier notifies the applicant of the availability of small group coverage through the small group market and through the carrier. The notice shall inform the applicant of his/her guarantee issue rights as detailed in Section 10-16-105(7.3)(a) and (c), C.R.S. This notice shall be in writing and shall be included as part of the denial of individual coverage letter. A copy of the denial letter and the notice concerning the availability of small group coverage shall be maintained by the carrier in the file with the original application.* [Emphasis added]

INDIVIDUAL NEW BUSINESS APPLICATIONS DENIED

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,500	50	5	10%

It appears the Company is not in compliance with Colorado insurance law in that, in some instances, it failed to provide the mandated written notice of the availability of coverage under a small group plan to applicants for individual coverage who also qualified as Business Groups of One (BG1) who were rejected for coverage under an individual plan.

The examiners reviewed a sample of fifty (50) individual new business declinations from a total population of 4,500. In five (5) of the fifty (50) files reviewed, the Company failed to provide the required notifications to individual applicants who were denied coverage under an individual plan, and who self-identified at the time of application as being as a BG1.

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-105.2, C.R.S., and Colorado insurance regulation 4-2-19. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised

its procedures to ensure that the mandated written notice of the availability of coverage under a small group plan is provided to Business Groups of One that are rejected for coverage under an individual plan to comply with Colorado insurance law.

Issue H4: Failure of the Company's Certificates of Creditable Coverage to reflect the full definition of a "significant break in coverage".

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1)(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule*. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S. states in part:

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

B. Colorado law concerning creditable coverage.

1. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

2. Colorado law requires health coverage plans to waive any exclusionary time periods applicable to pre-existing conditions for the period of time an individual was previously covered by creditable coverage, provided there was no significant break in coverage, if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. Colorado law prevails over the federal regulations.

3. Application of the rules regarding breaks in coverage can vary between issuers located in different states, and between fully insured plans and self-insured plans within a state. The laws applicable to the health coverage plan that has the pre-existing condition exclusion will determine which break rule applies.

4. Certifying creditable coverage

   Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance *must issue certificates of creditable coverage that reflect the definition of "significant break in coverage" found in Section 4.A. of this regulation.* [Emphasis added]

SMALL GROUP CANCELLATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
102 (Small Groups)	59 (Individuals)	59	100%

It appears the Company is not in compliance with Colorado insurance law in that the letter it sends to members of cancelled small groups as a certificate of creditable coverage titled "Health Insurance Certificate of Creditable Coverage" doesn't include any definition of "significant break in coverage" as defined in Section 4. A. of Colorado Insurance Regulation 4-2-18. Such full definition is required under Section 5. B. 4. The Company provided fifty-nine (59) electronically reproduced copies of letters sent to members of ten (10) groups randomly selected from the sample of fifty (50) cancelled groups reviewed. None of the certificates reviewed include the required reference to a significant break in coverage.

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its certificates of creditable coverage to reflect the full definition of "significant break in coverage" required by Colorado insurance law.

Issue H5: Failure, in some instances, to provide Certificates of Creditable Coverage.

Section 10-16-102, C.R.S., Definitions, states in part:

(13.7) "Creditable coverage" means benefits or coverage provided under:

(c) An individual health benefit plan;

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule*. [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S. states in part:

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances to *ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.*

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., *shall be as set forth in the federal regulations incorporated below.*

2. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

3. The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.:

45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). These sections concern the method for counting creditable coverage; requirements for providing certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates; and requirements for providing certificates of creditable coverage to those who were insured under individual plans, including the form and content of the certificates.

B. Colorado law concerning creditable coverage.

8. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

9. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation. [Emphases added]

45 C.F.R. 148.124 Certification and disclosure of coverage.

(b) General rules

(1) Individuals for whom a certificate must be provided; timing of issuance. A certificate must be provided, without charge, for individuals and dependents who are covered under an individual health insurance policy as follows:

(i) Issuance of automatic certificates. An automatic certificate must be provided within a reasonable time period consistent with State *law after the individual ceases to be covered under the policy*.

(2) Form and content of certificate –(i) Written certificate –(A) General rule. Except as provided in paragraph (b)(2)(i)(B) of this section, *the issuer must provide the certificate in writing* (including any form approved by CMS). [Emphasis added]

INDIVIDUAL CANCELLATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,074	100	11	11%

It appears the Company is not in compliance with Colorado insurance law in that, in some instances, it failed to provide Certificates of Creditable Coverage to individual members upon termination/cancellation of their health benefit plans.

The examiners reviewed a sample of 100 individual cancellation files from a total population of 5,074. In eleven (11) of the 100 files reviewed, the examiners were unable to find certificates of creditable

coverage issued to members (and/or their dependents) whose coverage under an individual health benefit plan was cancelled.

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that certificates of creditable coverage are provided to all individuals (and their dependents) whose coverage is cancelled to comply with Colorado insurance law.

Issue H6: Failure, in some instances, to provide Certificates of Creditable Coverage that reflect the correct dates of coverage under individual health benefit plans.

Section 10-16-102, C.R.S., Definitions, states in part:

(13.7) "Creditable coverage" means benefits or coverage provided under:

(c) An individual health benefit plan;

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule.* [Emphasis added]

Colorado Insurance Regulation 4-2-18, Concerning The Method of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S. states in part:

Section 2. Purpose and Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances to *ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.*

Section 5. Rules

A. Application of federal laws concerning creditable coverage.

1. The method for crediting and certifying creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., *shall be as set forth in the federal regulations incorporated below.*

2. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

3. The following sections of the federal regulations, adopted by the U.S. Department of Health and Human Services, are hereby incorporated by

reference and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S.:

45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). These sections concern the method for counting creditable coverage; requirements for providing certificates of creditable coverage to those who were insured under group plans, including the form and content of the certificates; and requirements for providing certificates of creditable coverage to those who were insured under individual plans, including the form and content of the certificates.

B. Colorado law concerning creditable coverage.

8. The method for crediting and certifying creditable coverage described in this regulation shall apply both to group and individual plans that are subject to Section 10-16-118(1)(b), C.R.S.

10. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation. [Emphases added]

45 C.F.R. 146.115 Certification and disclosure of previous coverage, states in part:

(3) Form and content of certificate.

(i) Written certificate.

(A) In General. Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (or any other medium approved by the Secretary).

(ii) Required information. The certificate must include the following

(F)(2) The date any waiting period (and affiliation period, if applicable) began and *the date creditable coverage began*;

(G) *The date creditable coverage ended*, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate. [Emphases added]

INDIVIDUAL CANCELLATIONS

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,074	100	12	12%

It appears the Company is not in compliance with Colorado insurance law in that, in some instances, it failed to provide certificates of creditable coverage that contained correct dates of coverage to individual members upon termination/cancellation of their health benefit plans.

The examiners reviewed a sample of 100 individual cancellation files from a total population of 5,074. In twelve (12) of the 100 files reviewed, the examiners noted that the certificates of creditable coverage issued to members (and/or their dependents) contained dates that did not correspond to the start and/or ending date of coverage for those members whose coverage under an individual health benefit plan was cancelled.

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure correct coverage dates are included in all certificates of creditable coverage to comply with Colorado insurance law.

Issue H7: Failure, in some instances, to provide written notice of the availability of Basic and Standard Health Benefit plans to business groups of one that were denied coverage for another group health plan due to risk characteristics. *(This was prior issue H1 in the market conduct examination report dated December 31, 2001.)*

Colorado Insurance Regulation 4-6-5, Concerning The Basic And Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S., states in part:

Section 4 Rules

H. If a small employer carrier denies coverage to a business group of one for any of its health benefit plans on the basis of risk characteristics, the denial shall be in writing and shall state with specificity the reasons for denial (subject to any restrictions related to confidentiality of medical information). *The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation shall include at least the following:*

1. A *general description of the benefits* contained in each such plan;

2. A price quote, in the manner required by Section 4.G of this regulation, for each plan if the business group of one is in its open enrollment period or a sample price quote reflecting current rates if the business group of one is not in its open enrollment period. In the case of a sample price quote, the small employer carrier shall disclose that the actual rates may be different than the sample rates if there are changes in small employer carrier's filed rates or application of rating factors; and

3. Information describing how the business group of one can enroll in such plans. The explanation shall be provided directly to the business group of one or through an authorized producer within the timeframes provided in Paragraphs G.1 and G.2. [Emphases added.]

BG1 DENIALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
30	27	5	19%

It appears the Company is not in compliance with Colorado insurance law in that, in some instances, it failed to provide the mandated written notice of the availability of the small group Basic and Standard Health Benefit plans, price quotes for those plans or instructions on how to apply for coverage under these plans to business groups of one who were denied coverage due to medical underwriting.

The examiners reviewed the entire population of thirty (30) small group new business declinations. Two (2) of the files reviewed were not actual declinations and the Company was unable to provide one (1) file, making the effective population twenty-seven (27) files. In five (5) of the twenty-seven (27) files reviewed, the Company failed to provide the required notifications to small group business groups of one applicants who were denied coverage.

Recommendation No. 25

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that BG1's that are denied coverage on the basis of risk characteristics are provided a written explanation of the availability of the basic and standard plans as required by Colorado insurance law.

Issue H8: Failure, in some instances, to provide written notification of the denial of coverage, including the specific reason(s) for denial to business group of one applicants who were denied coverage under a small group plan.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S., states in part:

Section 4 Rules

I. *If a small employer carrier denies coverage to a business group of one for any of its health benefit plans on the basis of risk characteristics, the denial shall be in writing and shall state with specificity the reasons for denial* (subject to any restrictions related to confidentiality of medical information). The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation shall include at least the following: [Emphasis added]

1. A general description of the benefits contained in each such plan;

2. A price quote, in the manner required by Section 4.G of this regulation, for each plan if the business group of one is in its open enrollment period or a sample price quote reflecting current rates if the business group of one is not in its open enrollment period. In the case of a sample price quote, the small employer carrier shall disclose that the actual rates may be different than the sample rates if there are changes in small employer carrier's filed rates or application of rating factors; and

3. Information describing how the business group of one can enroll in such plans. The explanation shall be provided directly to the business group of one or through an authorized producer within the timeframes provided in Paragraphs G.1 and G.2. [Emphases added.]

BG1 DENIALS

Population	Sample Size	Number of Exceptions	Percentage to Sample
30	27	5	19%

It appears the Company is not in compliance with Colorado insurance law in that, in some instances, it failed to provide written notification of the denial of coverage, including the specific reason(s) for the denial, to business groups of one applying for small group coverage.

The examiners reviewed the entire population of thirty (30) small group new business declinations. Two (2) of the files reviewed were not actual declinations and the Company was unable to provide one (1) file, making the effective population twenty-seven (27) files. In five (5) of the twenty-seven (27) files reviewed, the Company failed to provide the required written notification of the denial of coverage, including the specific reason(s) for the denial to business group of one applicants who were denied coverage under a small group plan.

Recommendation No. 26

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado insurance regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notifications of the denial of coverage, including the specific reason(s) for the denial is provided to business groups of one who are denied coverage due to risk characteristics as required by Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

> (2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents.* A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.* [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER 30 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,391*	50	11	22%

(*16% of all electronic claims)

Using ACL™ software, the examiners identified a summarized population of 2,391 electronic claims that were adjudicated beyond thirty (30) days during the period under examination. A random sample of fifty (50) such claims was selected for review. It appears that the Company is not in compliance with Colorado insurance law in that there were eleven (11) files out of the fifty (50) reviewed that appeared to be clean claims, but were not paid, denied, or settled within the required thirty (30) calendar days after the claim receipt date. All clean claims submitted electronically are to be paid, denied, or settled within thirty (30) calendar days of receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER 45 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
241*	50	2	4%

(*1% of all non-electronic claims)

Using ACL™ software, the examiners identified a summarized population of 241 non-electronic claims that were not paid, denied or settled within forty-five (45) days during the period under examination. A random sample of fifty (50) such claims was selected for review.

It appears that the Company is not in compliance with Colorado insurance law in that there are two (2) files out of the fifty (50) reviewed that appeared to be clean claims, but were not paid, denied, or settled within the required forty-five (45) calendar days after the claim receipt date. All clean claims submitted other than electronically are to be paid, denied, or settled within forty-five (45) calendar days of receipt.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
149*	50	14	28%

(*less than 1% of all claims)

Using ACL™ software, the examiners identified a summarized population of 149 electronic and non-electronic claims that were not paid, denied or settled within ninety (90) days during the period under examination. A random sample of fifty (50) such claims was selected for review from this population.

It appears that the Company is not in compliance with Colorado insurance law in that fourteen (14) claims reviewed did not appear to involve fraud, but were not paid, denied, or settled within the required ninety (90) calendar days after the claim receipt date. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) calendar days of receipt.

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law

Issue J2: Failure, in some instances, to pend unclean claims and to allow the required time for submission of additional information before denying.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

> (4)(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after the receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. *Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b) subject to resubmittal of the claim or the appeals process.* If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphases added.]

CLAIMS DENIED DUE TO MISSING INFORMATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
25,582*	100	10	10%

(*14% of all claims)

Using ACL™ software, the examiners identified a summarized population of 25,282 claims denied during the period under examination. A random sample of 100 such claims was selected for review. It appears that the Company is not in compliance with Colorado insurance law in that there were ten (10) files out of 100 reviewed where it appears the Company improperly denied the claim instead of pending and allowing the required time for required information to be provided.

Recommendation No. 28:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that any claims that require additional information are pended and held open for the required time period for the additional information to be submitted as required by Colorado insurance law.

Issue J3: Failure, in some instances, to correctly adjudicate claims resulting in erroneous denials and requiring subsequent, delayed correct adjudication and payment of claims.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(h) Unfair claim settlement practices:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; or

From a population of 25,582 denied claims received from January 1, 2007, through December 31, 2007, a randomly selected a sample of 100 denied claims was reviewed.

It appears the Company is not in compliance with Colorado insurance law in that at the time some claims were denied, the Company appeared to be in possession of the information needed to properly adjudicate the claims. Six (6) claims out of the 100 denied claims reviewed appeared to represent charges that should have been covered by the terms of the contract as they were subsequently reconsidered and paid.

DENIED CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
25,582*	100	6	6%

(*14% of all claims)

Recommendation No. 29:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that eligible claims are not incorrectly denied as required by Colorado insurance law.

Issue J4: Failure, in some instances, to provide required information regarding appeal rights to members whose claims were denied.

Section 10-16-113, C.R.S., Procedure for denial of benefits – rules, states in part:

> (1)(a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.
>
> (c) *If a health coverage plan denies a benefit because the treatment is an excluded benefit and the claimant presents evidence from a medical professional* licensed pursuant to the "Colorado Medical Practice Act", article 36 of title 12, C.R.S., or, for dental plans only, a dentist licensed pursuant to the "Dental Practice Law of Colorado", article 35 of title 12, C.R.S., acting within his or her scope of practice, *that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, such evidence establishes that the benefit denial is subject to the appeals process. The denial of such benefit shall be subject to the appeals provisions of this section and section 10-16-113.5.*
>
> (2) *Following a denial of a request for benefits by the health coverage plan, such plan shall notify the covered person in writing. The content of such notification and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner.* [Emphases added.]

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 2 Background and Purpose

> *The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Sections 10-3-1104(1)(h), 10-16-409(1)(a), and 10-16-113, C.R.S., in situations involving* utilization review and *certain denials of benefits for treatment, as described herein.* Among other things, Section 10-3-1104(1)(h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from insurance policies; promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based upon all available information. This regulation replaces Colorado Emergency Regulation 05-E-5 in its entirety.

Section 4 Definitions[1]

> A. *"Adverse determination"* means a determination by a health carrier or its designee that request for a benefit has been reviewed and, based upon the

information provided, does not meet the health carrier's requirement for medical necessity, or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated. An adverse determination *also includes a denial for a benefit excluded by a health coverage plan for which the claimant is able to present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit.*

Section 5 Compliance Requirements

E. A health carrier that does not allow an appeal, consistent with the procedures set forth in this regulation, of a benefit denial for a treatment excluded by the health coverage plan when the covered person presents evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply shall be deemed not to be in compliance with the requirement under the unfair competition and deceptive practice insurance statutes of Colorado that a carrier refrain from denying a claim without conducting a reasonable investigation based upon all available information. (Section 10-3-1104(1)(h)(IV), C.R.S.)

Section 6 Standard Utilization Review

A. A health carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.

C. Retrospective review determinations.

1. *For retrospective review determinations,* a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request. If the determination is an adverse determination, *the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E.*

E. Requirements for adverse determination notifications.

1. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

   a. An explanation of the specific medical basis for the adverse determination;
   b. The specific reason or reasons for the adverse determination;
   c. Reference to the specific plan provisions on which the determination is based;
   d. A description of any additional material or information necessary for the covered person to perfect the benefit request, including an

explanation of why the material or information is necessary to perfect the request;

e. If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

f. If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health coverage plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

g. If applicable, instructions for requesting:
   (i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph e. of this paragraph; or
   (ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph f. of this paragraph; and

h. A description of the health coverage plan's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision;

2. A health carrier must provide the notice required under this section in writing, either on paper or electronically. [Emphases added.]

CLAIMS DENIED AS "NOT A BENEFIT"

Population	Sample Size	Number of Exceptions	Percentage to Sample
533*	50	12	24%

(*2% of all denied claims)

As a result of a referral received from the Division's Consumer Affairs section, the examiners requested a supplemental sample of fifty (50) claims denied during the period under examination with denial reason code 017 – "Under your plan, this service is not covered". It appears that the Company is not in compliance with Colorado insurance law in that twelve (12) files out of the fifty (50) reviewed appeared to be subject to the appeal notice requirements outlined above, but the adverse benefit determination notices did not appear to include all required information regarding the reason(s) for the denial and the claimant's appeal rights as outlined in subsection 6(E) of Regulation 4-2-17.

Recommendation No. 30:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. and Colorado insurance regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all required information regarding the denial and notice of the right to appeal are provided in all instances required by Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure to provide the qualifying credentials of all panel members in the appeal decision letter as required pursuant to Colorado Insurance Regulation 4-2-17.

Section 10-16-113, C.R.S., Procedure for denial of benefits – rules, states in part:

> (2) Following a denial of a request for benefits by the health coverage plan, such plan shall notify the covered person in writing. The content of such notification and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, C.R.S. states in part:

> Section 11 Voluntary Second Level Review
>
> *H A decision issued pursuant to Subsection G. shall include:*
>
> *(1 The name(s), title(s) and qualifying credentials of the reviewer or members of the review panel;* [Emphasis added.]

SECOND LEVEL REVIEW ADVERSE DETERMINATIONS –Written notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
31	31	24	77%

It appears that the Company is not in compliance with Colorado insurance law in that it did not provide the qualifying credentials of one of the second level appeal panel members in the appeal decision letter in twenty (20) instances and provided no credentials at all in four (4) instances of the thirty-one (31) second level appeal files.

Recommendation No. 31:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §10-16-113, C.R.S., and Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that the names and qualifying credentials of the reviewer or members of the review panel are provided in the written notification letters regarding second level reviews as required by Colorado insurance law.

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